A THEORY EVALUATION AND PROGRAMME IMPLEMENTER DECISION ANALYSIS FOR TWO THERAPY- DRIVEN PROGRAMMES OPERATING IN THE DISABILITY AND REHABILITATION SECTOR

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COMPULSORY DECLARATION:

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works of other people has been attributed, cited and referenced.

Signature: Signed by candidate ..... Date: 15 / 06 / 2018

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EXECUTIVE SUMMARY

This dissertation focused on two therapy-driven programmes operating in the disability and rehabilitation sector in the Western Cape, South Africa. One programme is an inclusive education programme with a classroom component and parenting component to it and the other is a vocational rehabilitation programme. These two programmes, implemented by the Chaeli Campaign (CC), are aligned with the community-based rehabilitation model of service delivery. These programmes are implemented by personnel with a variety of qualifications, including community workers and occupational therapists. Key goals for programmes of this nature are to ensure that all persons with disabilities are active participants of socio-economic life, to ensure that the rights and dignity of all persons are respected and upheld and to reintegrate persons with disabilities into family and community life. Another goal of these programmes is to transfer skills from highly-skilled professionals to workers with less training and lay persons. With respect to the last-mentioned goal, the skills required to services persons with disabilities are redistributed, so that professionals such as occupational therapists are no longer solely responsible for serving these persons. Both programmes under evaluation in this document are implemented either exclusively or with help from occupational therapists.

Problem Statement: The problem statement is made up of two components. First, the underlying programme theories of the two therapy-driven programmes were not well articulated. According to CC's director, this poor articulation made it difficult for programme staff to describe their programmes to potential programme donors. Second, the organisation struggles to obtain funding from potential programme donors to finance the use of occupational therapists in their programmes. The difficulty in obtaining funding is assumed to be due to potential donors' belief that these programmes could be implemented at a reduced cost by community workers.

Method: The evaluator decided to conduct two programme evaluations to address the two aspects mentioned in the problem statement. First, programme theory evaluations were done to address the poor articulation of the programmes' theories. The programme theory evaluation aimed to elicit and articulate the underlying logic of each of the programmes, thus enabling the evaluator to assess their plausibility. Following this, three multi-criteria decision analyses (MCDAs) using the Analytical Hierarchy Process (AHP) were conducted. The MCDAs were intended to establish which implementer (an occupational therapist or a community worker) is most preferred by CC's current programme stakeholders. The participants of the MCDA included programme beneficiaries, current programme donors, field experts, programme facilitators and programme staff. **Results:** Programme theories were made explicit and articulated. These were then depicted as logic models. Results indicate that when assessed against social science and evaluation literature, the programme theories elicited in this dissertation are plausible. The MCDA results indicate that programme stakeholders prefer occupational therapists for technical aspects of programme delivery and prefer community workers for psychosocial aspects of rehabilitation, such as relationship-building and providing emotional support. Of note is that stakeholders weighted the perceived benefits of occupational therapists and community workers as more important than the costs associated with each implementer. The results from the MCDA highlight that programme stakeholders perceive the benefits of implementers (occupational therapists and community workers) to be more important than their associated costs. The evaluator assessed these results against social science literature and found that in general, stakeholders value benefits more than costs of implementing personnel.

Recommendations: Recommendations are made to the organisation to describe their programmes' theories more coherently and more clearly express their need for both community workers and occupational therapists.

Conclusions: Rather than considering cost, potential donors should consider that occupational therapists and community workers serve specific purposes in programme implementation. Their purpose, rather than their cost, should be prioritised in order for programmes to be effective. The field should be made aware of this disjuncture, while costs are important considerations, stakeholders in the field of disability and rehabilitation should not compromise on the quality of services in order to reduce programme costs.

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Chapter 1: Introduction

This dissertation details two evaluations conducted on two therapy-driven programmes operating in the disability and rehabilitation sector[1]. In this chapter, the organisation providing the programmes is introduced, Chaeli Campaign, as are the programmes themselves. Chapter 1 concludes with the problem statement, evaluation scope and guiding evaluation questions. In Chapter 2, definitions and conceptualisations of disability are discussed. Further, in Chapter 2 the evaluator focuses on providing a context for community-based rehabilitation (CBR), as the two programmes being evaluated are aligned to CBR.

The Chaeli Campaign (CC) is a registered non-profit organisation (NPO) based in Cape Town. The organisation was founded in August 2004. CC provides services to a range of beneficiaries, from young children to adults, those with disabilities and those who interact with people with disabilities. Each of the organisation's seven programmes addresses a different need (discussed in more detail below). Although the content varies from programme to programme, all provide education or rehabilitative services. These programmes aim to support the inclusion of people with disabilities into society (Chaeli Campaign Organisation Profile, 2016). CC aims to include people with disabilities into society by engaging with individuals and communities.

[1] A brief history of the Disability Rights Movement since the 1980's and its influence on South Africa's national response to disability and rehabilitation is provided in Appendix A.

The Chaeli Campaign's objectives are to:

- "*Mobilise the minds and bodies of children with disabilities throughout South Africa by providing various interventions linked to their mobility and educational needs;*
- *Source and utilise resources and facilities to provide assistance to individuals with disabilities;*
- *Work in collaboration with other organisations for the advancements of people with disabilities, and*
- *Act as a global catalyst for the inclusion of people with disabilities in society and promoting disabilities awareness with partner centres/organisations/ and communities*"

(Chaeli Campaign Organisation Profile, 2016, p.1).

The organisation has two clusters of programmes as it aims to achieve its mission through engagements at both an individual (primary beneficiaries) and societal level (secondary beneficiaries). The programmes are grouped into therapy-driven programmes and non-therapy driven programmes. Therapy-driven programmes are for people with disabilities (primary beneficiaries), whereas non-therapy driven programmes are for community members (secondary beneficiaries). The focus of this dissertation is the therapy-driven programmes.

The primary beneficiaries range in age and type of disability, as well as their therapeutic requirements. Secondary beneficiaries are, in most cases (although not exclusively), not themselves persons with disabilities. They are generally people with an interest in disability-related issues, or those who participate in the non-therapy, advocacy-related programmes. The organisation attempts to influence its secondary beneficiaries to have positive attitudes regarding disability. Secondary beneficiaries can then influence the wider community to view disability more positively. Figure 1 below, depicts CC's programmes.

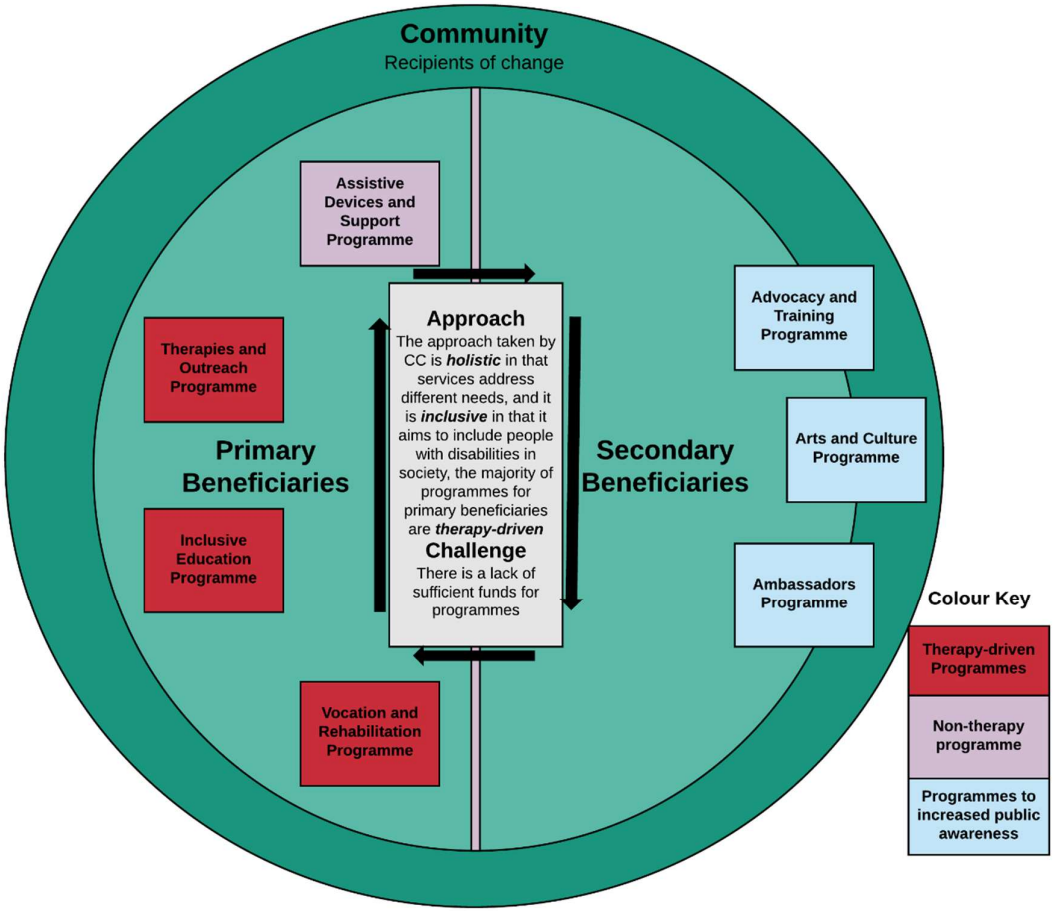

Figure 1. Overview of Chaeli Campaign's programmes.

Note. The left inner half circle represents primary beneficiaries, whereas the right inner half circle represents secondary beneficiaries. The surrounding outer circle represents community members who are indirectly affected by programmes to increase public awareness. The red blocks on the left inner circle indicate therapy-driven, primarily targeting people with disabilities. The purple block indicates non-therapy driven programme targeting people with disabilities. Blue blocks indicate non-therapy driven programmes which increase public awareness, targeting both people with and without disabilities. The centre rectangle describes CC's approach and challenges relating to programmes.

Figure 1 shows how certain programmes cross the boundary between the secondary beneficiaries and the wider community. This overlap represents how secondary beneficiaries, having received services, interact with other communities. In so doing, secondary beneficiaries sustainably extend the change in attitude or knowledge about including people with disabilities into society. Thus, community members (located in the outer circle of Figure 1) can interact with secondary beneficiaries in the hope that they can affect change in their communities.

As can be seen in Figure 1, CC's approach offers an array of services to various groups. As an organisation, their main challenge is insufficient funding to maintain the therapy-driven programmes. This challenge is discussed in more detail further down.

Therapy-Driven Programmes

Two of the therapy-driven programmes, namely, the Inclusive Education Programme (consisting of two programme components) and the Vocation and Rehabilitation programme are discussed in detail.

Inclusive Education Programme.

This programme is implemented at two sites, one site focused on an Early Childhood Development (ECD) classroom setting (targeting both children and teachers), and the other targeting parents of pre-schoolers. Some of these learners have disabilities. The site targeting ECD-children and teachers will be termed the classroom component, and the site targeting the parents, the parent component. Early Childhood Development (referred to as ECD) is the phase of education and childhood development from birth to grade R, or from birth to the age of eight or nine for children with disabilities and development delays (Department of Basic Education, 2015; Department of Social Development, 2016). Programmes working in the ECD sector aim to promote the development of children's' cognitive, emotional, social, spiritual, communicative and physical development abilities (Department of Social Development, 2016; Johnson, Christie, & Yawkey, 2012). This programme is designed, managed, supervised and implemented by an occupational therapist. Community workers are also involved in implementing the programme, these workers are trained in community development and rehabilitation.

Classroom component of the Inclusive Education Programme.

Through this component, CC hopes to create more inclusive pre-school spaces for children with disabilities. This programme offers ECD services and so it fits within the educational domain of the CBR Matrix[2] (Figure 3, page 28) meaning this programme component delivers educational services to disability inclusive pre-schools.

The component's implementing staff stated that ECD-children in Masiphumelele lack knowledge about disability. Insufficient or inaccurate knowledge, according to CC, leads to children being afraid of people with disabilities. To address

[2] The Community-Based Rehabilitation (CBR) Matrix is introduced in Chapter 2 (page 28).

this need, CC runs the classroom component of the Inclusive Education Programme. It does this by providing funding, an occupational therapist and a community worker.

There are three sets of activities within the classroom component. The first of these is geared towards children. It includes: throwing and catching balls; moving and passing a beanbag; perceptual art; scissor cutting; puzzle-building and singing songs. These activities provide the occupational therapist an opportunity to observe children's abilities. In doing this, the occupational therapist is able screen children who may have a development delay or disability.

The next set of activities consists of: a group discussion on what disability is; a discussion and encouragement on befriending children with disabilities; teaching children basic Sign Language and experiential learning where children ride in wheelchairs and are blind-folded. It is hoped that by giving children an opportunity to have fun while learning more about disability, this will reduce children's fear of people with disabilities.

Activities focused on teachers include a discussion on how to support children with developmental delays in the classroom. If teachers have questions about disability, the community workers and the occupational therapist address these. The occupational therapist and community workers inform teachers on how to go about approaching parents of children who are not achieving developmental milestones, and how to refer these parents to either a clinic or to CC.

Parent component of the Inclusive Education Programme.

The parent component of the programme is aligned with the education and empowerment aspects of the CBR Matrix (Figure 3, page 28), as its over-arching aim is to empower parents, most of whom have children with disabilities, to support their children's school readiness. The programme is delivered in a low-income area, Philippi.

CC's implementing staff stated that there are three needs targeted by this programme component. Firstly, parents are not aware of the role they play in preparing their children for school. Secondly, those parents who are willing to support their children's school readiness lack the confidence required to support school readiness. Supporting school readiness refers to facilitating a child's development at home. For example, if parents know what is expected of children at school, they can assist their children with homework and better communicate with teachers about their children's

progress and development. Thus, CC familiarises parents with what is expected of children at school. Lastly, there is a lack of parent-teacher communication, as parents are, according to CC, intimidated by teachers. The parent component was developed to address these concerns. CC provides funding to employ a community worker and an occupational therapist to address these needs. The community worker is a member of the community, who herself is a parent of a child with a disability. Together, the implementers deliver three sets of activities:

1: Implementers affirm parents for the way they are already supporting their children and use an analogy of a three-legged pot to emphasise the importance of the parent, teacher, and professional relationship in supporting a child's development.

2: The implementers use aids to show parents what is expected of children developmentally, these aids include cut-outs, drawings and writing. Cut-outs, drawings and writing from a child who has reached a developmental milestone are shown to parents and compared to those made by a child who had not yet reached the developmental milestone. Additionally, parents are shown a beanbag exercise that is used in the classroom component. Lastly, this set includes teaching parents how to hold and cut with scissors correctly, and how to hold pencils correctly. In so doing, parents can see what is expected of a child.

3: Implementers facilitate a discussion covering the following themes: the importance of play, the importance of clear speech and listening at school and the basics for educational success, such as; nutrition requirements for children, good health, sleep; emotional security, and home-work routines. Together, these activities are intended to change negative attitudes held by some parents about the role these parents have in their children's lives. These activities also upskill parents to be better equipped to support their children's school readiness.

Vocation and Rehabilitation Programme.

The overarching goal of the Vocation and Rehabilitation Programme is to enable young adults with disabilities to participate more fully in society through building vocational skills. Thus, it based on one component of livelihoods programmes which aim to make persons more employable (CBR Matrix, Figure 3, page 28). This programme consists primarily of craft workshops, developed in response to four needs. Firstly, care givers often do most tasks for young adults with disabilities (YAwD), contributing to YAwD being passive, and over-

dependent on their caregivers (D. Phillips, personal communication, 20th August 2017). CC's programme staff stated that this is due to many people underestimating the abilities of YAwD. Linked to this is that many YAwD do not believe they can complete tasks themselves (D. Phillips, personal communication, 20th August 2017). In the literature, this is called self-exclusion, which is the belief that one's disability means that one cannot contribute or fully participate in an activity (Finkenflügel & Rule, 2008). Self-exclusion often results in YAwD being less likely to make decisions for themselves (Finkenflügel & Rule, 2008).

Secondly, parents of YAwD usually take responsibility for arranging social activities on behalf of their children (D. Phillips, personal communication, 20th August 2017). These efforts however, are usually arranged to suit the parents' lifestyles, or with the parents' own peers. As such, YAwD often socialise with people outside their peer-group, resulting in limited opportunities to practice age-appropriate communication skills (D. Phillips, personal communication, 20th August 2017). CC believes this contributes to YAwD having low confidence in communicating with people. According to CC, this results in YAwD feeling isolated from spontaneous, meaningful interaction with peers, which is the third need this programme aims to address.

Lastly, according to CC, there are limited accessible vocational opportunities for YAwD. Resulting in little or no opportunity to fully participate in the economy.

CC attempts to address these needs by offering craft workshops to YAwD, these workshops focus on teaching social skills as well as providing vocational skills development. The workshops are implemented and supervised by an occupational therapist who is supported by volunteer facilitators. Most of the facilitators are family members or carers of the YAwD. Some of the recipients have severe mobility restrictions, as such, the facilitators are there to a) provide assistance with mobility, and b) socialise with peers who also care for YAwD.

The act of making crafts is used to facilitate other lessons embedded within the programme. First, there is a changing-tasks lesson, this refers to YAwD having to stop certain tasks and start working on other tasks. Second, the transference lesson refers to learning or practicing using certain craft tools, and then using that same tool but in a different way, or on a different project. Similarly, when YAwD have to share their art supplies, they practice communication skills, and these skills are then transferred to other contexts, such as their homes. The next programme lesson is the participation

and inclusion lesson. This refers to facilitators and staff encouraging YAwD to participate and include themselves in group activities. Lastly, the social lesson consists of group outings, where YAwD can socialise and chat informally with their peers, as well as with wider community members.

Collectively these components are intended to change behaviour and support the development of new skills in the recipients.

Problem Statement and Scope of Evaluation

In an initial meeting, the director of CC explained that CC's two therapy-driven programmes had two main challenges. These challenges formed the research questions that this evaluation attempts to address. First, the director identified the need to better articulate what CC's therapy-driven programmes aim to do and how they achieve these goals. The second need was to clarify whether an occupational therapist, community workers or both, should implement CC's therapy-driven programmes. These needs are discussed below.

First, CC has struggled to articulate to potential funders what it is that their therapy-driven programmes do (Z. Grobler Mycroft, personal communication, 27th February 2017). Prior to this evaluation CC had not undergone any programme evaluation and did not have documented programme theories. According to Funnell and Rogers (2011) programme theories, obtained through programme evaluation, can be used to articulate programme activities and intended outcomes, as well as to identify data needs for future monitoring and evaluation of programme outcomes. Therefore, CC may benefit from developing programme theories to help the organisation articulate their programmes to other stakeholders.

Second, CC's director explained that the Vocation and Rehabilitation Programme is run by an occupational therapist, who is the only employee responsible for implementing the programme. The Inclusive Education Programme components employ an occupational therapist to oversee and implement both programme components. CC also employs community workers to assist the occupational therapist with implementing the Inclusive Education Programme.

The director of CC views the use of occupational therapists in both programmes as integral to the success of these programmes (Z. Grobler Mycroft, personal communication, 27th February 2017). CC, however, has not consulted programme stakeholders (such as current programme donors, implementing staff or beneficiaries)

as to whether they agree that occupational therapists are integral to the programme's success. Thus far, potential programme donors have, according to CC, been reluctant to pay for the use of occupational therapists. This is due to a perception amongst potential donors that CC's programmes could be implemented at a reduced rate by community workers (Z. Grobler Mycroft, personal communication, 27th February 2017). This has contributed to CC's ongoing financial insecurity, specifically in terms of maintaining the costs associated with occupational therapists (Z. Grobler Mycroft, personal communication, 27th February 2017).

Given that CC is an NPO, and therefore reliant on donor funding, CC requires a strong justification for using occupational therapists if they wish to obtain the necessary funding from potential programme donors (Boyce & Ballantyne, 2000).

In order to develop such a justification, this evaluation drew on current stakeholder opinions to: a) elicit stakeholder's perception which of elements of the programmes are most important and b) to establish which of the two workers, occupational therapists or community workers, are the preferred implementers of the therapy-driven programmes. Thus, this part of the research is based on cost-benefit analysis, examining the two implementers' benefits as well as examining how programme stakeholders assess the costs of each implementer. Therefore, in deciding on an implementer for therapy-driven programmes, CC needs to consider both tangible (perceived costs of implementers) and intangible (perceived benefits of implementers such as their abilities to promote change in beneficiaries) factors. In line with Article 3 of the United Nation's (UN) Convention on the Rights of Persons with Disabilities (UNCRPD) (UN, 2006), persons with disabilities, their families and communities should be included in making decisions regarding interventions which will affect them. Because of Article 3 of the UNCRPD, it is important that this evaluation includes programme stakeholders in choosing between two implementers (community workers versus occupational therapists).

To adequately address the two elements seen in the problem statement, this evaluation was conducted in two phases. Phase 1 was a theory evaluation, whereas Phase 2 utilised partial economic evaluation to establish the most preferred

implementer, occupational therapist or community worker, for the Inclusive Education Programme components and the Vocation and Rehabilitation Programme[3].

The evaluator needed to include a community worker as an alternative for the Vocation and Rehabilitation Programme even though CC does not currently employ a community worker on this programme. This is because an alternative was required to serve as a comparison for deciding on the most preferred worker. Given that CC already employs community workers to implement other programmes, it made sense to use community workers, rather than introducing a new alternative, as an alternative by which occupational therapists could be compared[4].

Evaluation Questions

This dissertation is guided by the following evaluation questions:

1) What are the programme theories for the Inclusive Education Programme and the Vocation and Rehabilitation Programme?

   a) Are these theories plausible?

2) Who, according to CC's stakeholders, is the preferred implementer for the Inclusive Education Programme and for the Vocational and Rehabilitation Programme?

The next chapter provides the reader with contextual information about disability, service delivery, inclusive education and vocational rehabilitation.

[3] When the evaluator presented the proposal for her dissertation to the board of evaluators, one requirement for her to proceed with the dissertation was to use a partial economic method, namely, multi-criteria decision analysis (MCDA). The reason given for this was that CC's problem statement is centred on a cost/benefit issue, as such, methods aligned with economic evaluation are preferred to adequately address CC's problem statement. This method was not included as part of the course material, and the evaluator and her supervisor both had to familiarise themselves with conducting MCDAs without being trained or guided by an expert in MCDA.

[4] The reader may want to know why only two of CC's three therapy-driven programmes are addressed in the evaluation questions above. As seen in the problem statement, the Inclusive Education Programme and the Vocation and Rehabilitation Programme both make use of occupational therapists to implement each session of the programmes. The remaining therapy-driven programme, the Therapies and Outreach Programme does not rely on full-time occupational therapist input. Given that CC's problem statement relates to difficulty in obtaining funding for programmes using occupational therapists, the Therapies and Outreach Programme was not included in the evaluation. The evaluator did elicit programme theories for the Therapies and Outreach Programme which will be made available to CC, but due to space constraints, the evaluator did not include this in the final dissertation.

Chapter 2: Disability and Rehabilitation

Disability is not an easily defined concept as there are various conceptualisations and understandings of it (Velema & Cornielje, 2016). Velema and Cornielje (2006) argue that none of the traditional definitions, when viewed on their own, are sufficient to describe the way in which disability is experienced. However, given that interventions for persons with disabilities are informed by the way in which disability is conceptualised and defined, it is worth highlighting a few definitions from key documents and organisations operating in the field of disability and rehabilitation (Heap & Morgans, 2006; Mji et al., 2013; Velema & Cornielje, 2016).

Definitions and Conceptualisations of Disability

According to the UNCRPD, disability is an evolving concept and persons with disabilities are:

> *"those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others"*
>
> (UN, 2006, p.4).

The World Health Organisation (WHO), an influential organisation that has authored standards and guidelines which are used in delivering services to persons with disabilities, provides a similar definition of disability, defining it as:

> *"…an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual (environmental and personal) factors"*
>
> (WHO, 2015, p.1).

The above two definitions are similar in that they both highlight components of disability, such as participation restriction, activity limitation and health impairment. While identifying these components provides readers with some indication of how disability may be experienced, both definitions are incomplete because they do not operationalise disability. An influential document, the International Classification of Functioning, Disability and Health (ICF) (2002) operationalise the definition put forward by the WHO (2015) that,

according to Velema and Cornielje (2016) goes further than any other in operationalising disability. According to the ICF, disability is experienced to various degrees, occurring when there is a break down between a) contextual factors (a person's physical environment and personal factors such as character traits) and b) health conditions (impairments) (WHO, 2002).

Depending on the type of break down, body function and structure and performance of activity; the degree to which one can participate in society may be affected in different ways for different individuals (WHO, 2002). As such, disability can be understood as highly-individualised (WHO, 2002). The extent of a person's disability is therefore dependent on where and how the dysfunction manifests, as well as on where a person is positioned in society (WHO, 2002). Figure 2 depicts the ICF's conceptualisation of disability as described above.

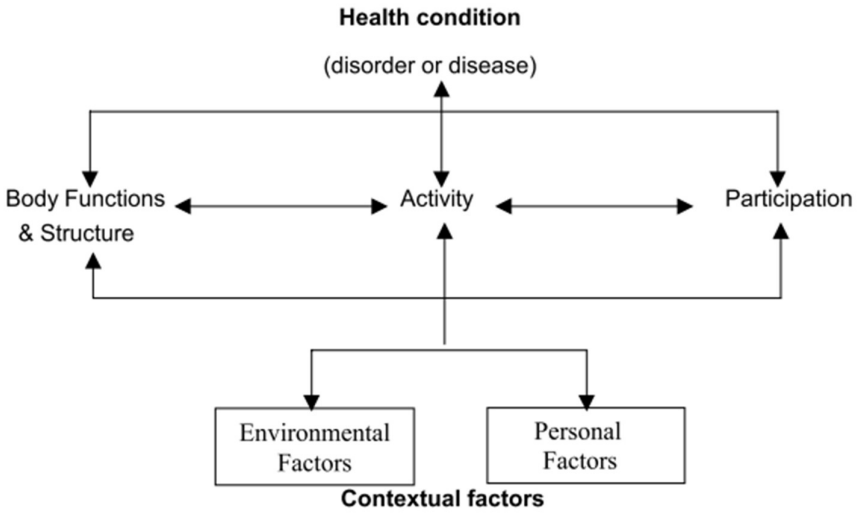

Figure 2. the International Classification of Functioning, Disability and Health by the World Health Organisation (2002, p.9).

As seen in Figure 2, different factors contribute to how an individual experiences disability, these components can be used to design interventions (WHO, 2002). For example, some interventions may act at the social or contextual level by empowering the person with a disability. Whereas other interventions may operate at the medical level by reducing the effect of, or minimising, an impairment (WHO, 2002). Thus, it is currently accepted that persons with disabilities require an array of interventions to adequately address social and medical factors associated with

disability in a comprehensive and holistic manner (Department of Social Development, 2016; ILO, UNESCO, & WHO, 2010). One approach to delivering holistic disability and rehabilitation services is through Community-Based Rehabilitation (Wirz & Thomas, 2002), the next section provides a review of literature on Community-Based Rehabilitation.

Community-Based Rehabilitation

Community-Based Rehabilitation (CBR) was originally seen as an approach to make rehabilitation more accessible to people with disabilities (ILO, WHO, & UNESCO, 2010). It was developed out of the awareness that institution-based rehabilitation can be inaccessible for many people with disabilities, especially in developing countries (Mannan & Turnbull, 2007). CBR has been implemented in various contexts, and this has led to different conceptualizations of the approach (Rule, Lorenzo, & Wolmarans, 2006). In 2004, CBR was defined as follows:

> "*CBR is a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families, organizations and communities, and the relevant governmental and non-governmental health, education, vocational, social and other services*"
>
> (ILO, UNESCO, & WHO, 2004, p. 2).

Although there are different conceptualisations of CBR, the publication of the WHO's CBR Guidelines in 2010 is commonly accepted as a strategy to realise optimal rehabilitation and support (Mannan et al., 2012; UN, 2006; Wirz & Thomas, 2002). The WHO's CBR Guidelines include principles such as:

- Participation of persons with disabilities in implementation and monitoring of interventions,
- Inclusion of persons with disabilities into mainstream discourses and activities,
- Sustainability in that efforts of these programmes should have long standing effects in communities, and
- Self-advocacy of persons with disabilities in defining how interventions are implemented.

(ILO, UNESCO, WHO, 2010, p.25).

In South Africa, CBR is used by the government, this approach and philosophy underpins national rehabilitation interventions as seen in the Framework on Disability and Rehabilitation Strategy (Chappell & Johannsmeier, 2009; Department of Health, 2015). Given the differing needs of persons with disabilities, CBR service providers vary significantly with regards to the services that they provide and the ways in which they provide them (WHO et al., 2010). This results in flexible approaches to implementing CBR. Thus, despite being central to South Africa's national approach to addressing disability related needs, there is still no common strategy for implementing CBR programmes in South Africa (M'Kumbuzi & Myezwa, 2016). There are also still questions pertaining to the efficiency and effectiveness of CBR (Finkenflügel, 2004; Mannan & Turnbull, 2007; Velema & Cornielje, 2016). The next section of this chapter examines the available evidence for the efficacy of CBR.

Evidence for the efficacy of CBR.

Figure 3 (page 28) shows the various sectors that CBR interventions operate in, as well as the goals of those interventions, as identified by the WHO.

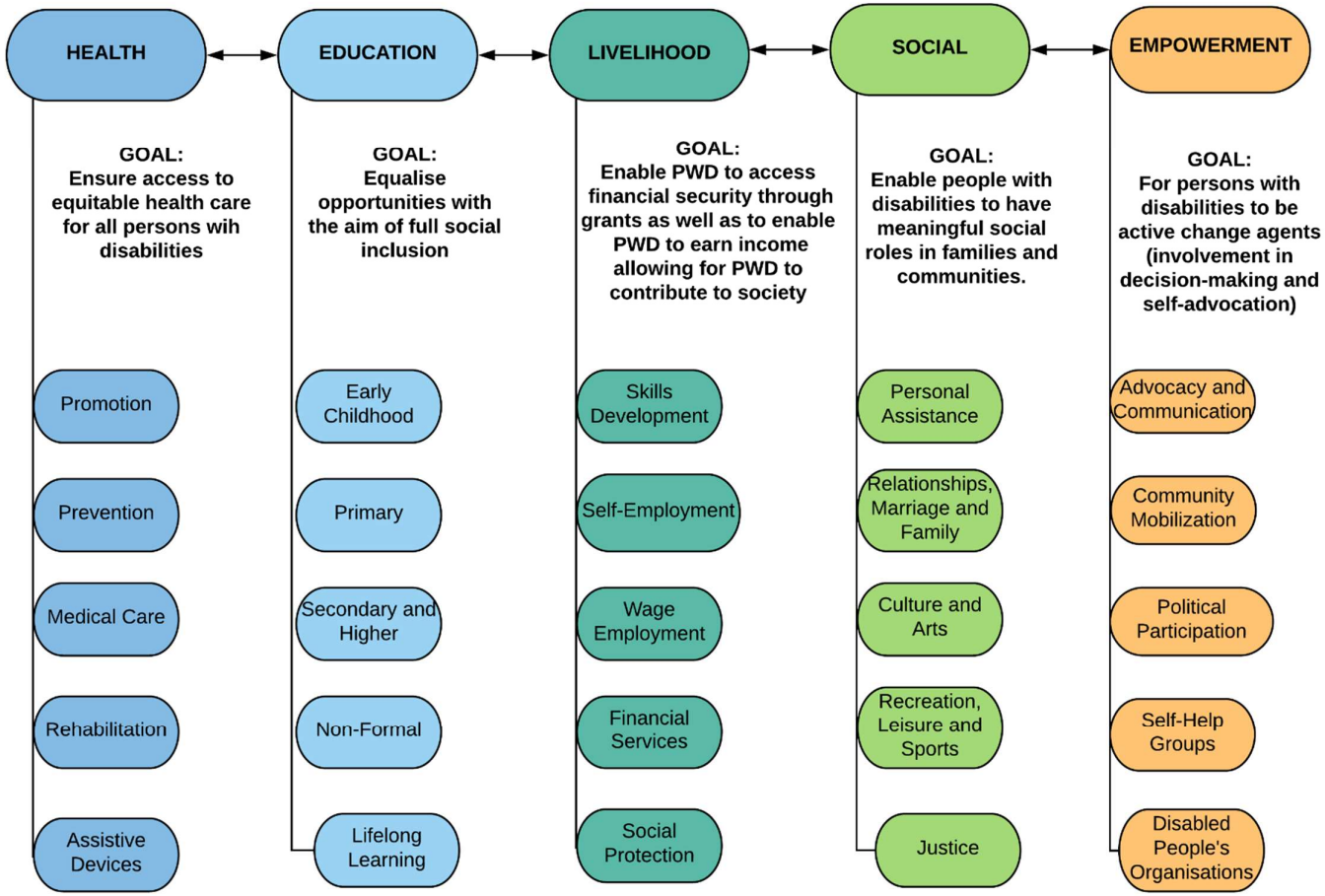

Figure 3. Community-Based Rehabilitation Matrix, adapted from the International Labour Organisation (ILO), The United Nations Educational, Scientific and Cultural Organisation (UNESCO) and The World Health Organisation (WHO) (2010, p.25).

Figure 3 shows the five sectors in which CBR interventions usually operate: health, education, livelihood, social and empowerment. Each sector's goal is listed below the name of the sector. Figure 3 also shows the different services that CBR interventions may offer, such as promotion, prevention, medical care, rehabilitation or providing assistive devices.

Evidence for efficacy is typically discussed in relation to this CBR Matrix (Figure 3). The evaluator reviewed recent published evaluations on the efficacy of CBR in each of the sectors identified in Figure 3. Table 1 on the following page documents the findings relating to the evidence for efficacy.

Table 1

Evidence for Efficacy of Community-Based Rehabilitation

Health	Education	Livelihoods	Social	Empowerment
Increased access to obtaining assistive devices *(p<.0.5)* (Biggeri et al, 2012; Bowers, Kuipers, & Dorset, 2015). Beneficiaries increased in mobility (Chappell & Johannsmeier, 2009). Beneficiaries of a CBR programme increased in performance on ADL (Chappell & Johannsmeier, 2009; Eide, 2006).	Able bodied children reported greater levels of acceptance of children with disabilities in mainstream classroom settings (Velema, Ebenso, & Fuzikawa; 2008). A CBR programme providing training for parents to help their children with intellectual disabilities complete homework, but there was no difference between the treatment and control groups (Shin et al., 2009). CBR has been found to aid in facilitating the adjustment process as well as integrating persons with disabilities into educational settings (ILO, UNESCO, & WHO, 2010).	CBR had a positive impact on access to pensions and allowances after 4 years, this effect was found to be maintained at 7 years (p<0.001) (Biggeri et al, 2012; Bowers et al., 2015). In the South African context, endemic poverty and high transportation costs prevents many persons from accessing programmes that are meant to improve skills and link persons with disabilities to employment opportunities (Chappell & Lorenzo, 2012). After four years of programme involvement, beneficiaries of a CBR programme reported an increase in accessing employment *(*Biggeri et al, 2012; Bowers et al., 2015).	Strengthened family relationships of persons with disabilities were reported (Chappell & Johannsmeier, 2009). Chappell and Lorenzo (2012) reflect on the many barriers hindering social participation that persons with disabilities in the Western Cape, South Africa still face. Increased social participation of persons with disabilities (Eide, 2006).	CBR increased community mobilisation (Chappell & Johannsmeier, 2009). CBR increased the self-esteem and self-confidence of persons with disabilities (Chappell & Johannsmeier, 2009). Increased involvement in community decisions (Biggeri et al, 2012; Bowers et al., 2015).

Overall, Table 1 shows that the evidence for CBR is mixed. Assessing the impact and efficacy of these interventions is difficult given that CBR interventions vary in their approaches to services delivery interventions (Bowers et al., 2015). To further examine this, evidence for the education and livelihoods sectors is briefly discussed, as these two sectors most closely align with the programmes being evaluated.

Historically interventions have been based on a medical model of disability, and this has resulted in fragmented services which have failed to meet the needs of people with disabilities, especially for marginalised groups (Engelbrecht, Howell, & Bassett, 2002). As such, a key goal for educational CBR interventions is to equalise opportunities with the aim of involving persons with disabilities in economic and social activities (Engelbrecht et al., 2002; WHO et al., 2010).

As seen in Table 1, Shin et al., 2009 found no significant difference between treatment and control groups in a study of a CBR programme providing training for parents to help their children with intellectual disabilities complete homework. However, CBR has been found to integrate persons with disabilities into educational settings (WHO et al., 2010). Additionally, as seen in Table 1, in the education sector, CBR programmes have led to children without disabilities being more accepting and respectful of children with disabilities in mainstream school settings (Velema et al., 2008).

Programmes in the livelihoods component aim to enable persons with disabilities to access financial security through grants or to enable persons with disabilities to earn an income, allowing for persons with disabilities to contribute to society economically (WHO et al., 2010). As seen in Table 1, under the livelihoods column, there is evidence for efficacy in terms of persons with disabilities accessing grants and employment because of a CBR programme. However, in the South African context, endemic poverty and high transportation costs prevents many persons from accessing programmes that are meant to improve skills and link persons with disabilities to employment opportunities (Chappell & Lorenzo, 2012). These examples illustrate that while CBR has been effective in some contexts, it has been found to be lacking in other contexts.

There is a need for more research on CBR interventions, not just to assess the effectiveness of interventions, but also to focus on how to implement services that achieve the intended outcomes effectively (Mannan & Turnbull, 2007). Given that many organisations lack funding, CBR service providers are increasingly under

pressure to demonstrate their efficacy (Mannan & Turnbull). One way to do this is through researching the utilisation of service delivery mechanisms, such as the personnel employed to deliver CBR interventions (Boyce & Ballantyne, 2000; Mannan, MacLachlan, & McAuliffe, 2013; Mannan & Turnbull, 2007).

Personnel of CBR programmes.

The tools and mechanisms used to deliver CBR interventions differ from context to context. This is also true for personnel employed to implement CBR interventions, as there is a wide range of persons delivering CBR programmes both nationally and internationally (Finkenflügel, 2004). There are, ideally, three categories of workers employed on a CBR programme (Bury, 2005). These are:

a) grass-roots level workers: unskilled workers who live in the community in which they work, who provide assistance and non-medical support on programmes,

b) mid-level workers: semi-skilled workers who carry out some more complex tasks and run programmes themselves and

c) professionals: supervisors of mid-level workers or highly-trained medical staff providing specialist skills (Bury, 2005).

Many CBR programmes operate in under-resourced areas and are thus often under pressure to be efficient in their expenditure (Ataguba et al., 2012). Because of the high cost and expertise required to utilise all three categories of workers in programme implementation, some programmes use only community-based workers and professionals (Ataguba et al., 2012).

Employing community-based workers to deliver CBR interventions has been formalised as a strategy to address what has been described as a human resource crisis in the implementation of CBR interventions (Ataguba et al., 2012). The human resource crisis refers to two deficiencies: a shortage of professionals (such as rehabilitation therapists and doctors needed to provide services to persons with disabilities) and a skills gap (between the skills the professionals have and the skills that are needed for CBR interventions to be effective) (Ataguba et al., 2012). While South Africa has a sufficient number of relevant professionals, these professionals are unequally distributed within society (Ataguba et al., 2012). The majority of occupational therapists, and similarly skilled professional, operate in wealthier middle-class suburbs. It would not be affordable to hire these professionals in the poorer areas. In order to provide appropriate and equitable services there is a pronounced need to

identify solutions, such as employing community-based workers, to meet the varying health, social and economic needs of persons with disabilities in an affordable and sustainable way (Ataguba et al., 2012; Mannan et al., 2013). Employing community-based workers to address this human-resource crisis is based on the thinking that community-based workers are available and can be trained to perform some of the basic medical and therapeutic tasks, to address the therapeutic needs of persons with disabilities (WHO et al., 2010).

Community-based workers.

Van Rooyen (2007) and Mannan et al (2013) note that there is no common terminology used to describe community-based workers and, depending on the context, these workers have varying job titles and job descriptions. Examples of job titles for community-based workers include: community health workers, community home-based carers, community-based rehabilitation workers, community development workers, community workers or community rehabilitation facilitators (Chappell & Johannsmeier, 2009; Lorenzo, Van Pletzen, & Booyens, 2015). Community-based workers are all members of the communities that they serve, so they can be understood as one group, however their roles and functions can vary greatly (Ataguba et al., 2012; Lorenzo, van Pletzen, & Booyens, 2015; van Rooyen, 2007). For example, while community home-based carers service beneficiaries in their own homes, community-based health workers work with wider communities and engage in health development (van Rooyen, 2007).

Despite the subtle differences in the various roles fulfilled by community-based workers, they all provide disability and rehabilitation-related services in under-serviced or impoverished areas and aim to increase the coverage and availability of these services (Ataguba et al., 2012; Finkenflügel & Rule, 2008; Walker & Jan, 2005).

Community-based workers are usually supervised by professionals or trainers with CBR training, as they deliver hands-on rehabilitation (Dawad & Jobson, 2011). These hands-on tasks include identifying persons with disabilities, providing information on disability and rehabilitation to community members and persons with disabilities, linking persons with disabilities to professional services and implementing services (ILO et al., 2004). Community-based workers are also involved in mobilising communities, doing advocacy work, navigating local power relations and equalising opportunities (Chappell & Johannsmeier, 2009; Finkenflügel & Rule, 2008). Thus,

community-based workers typically identify needs within communities and respond to these using community resources. These workers are able to engage more closely with communities of persons with disabilities (Dawad & Jobson, 2011).

Community-based workers often need to respond to complex community needs as they arise, therefore, their training needs to be broad (van Rooyen, 2007). This broad training usually consists of practical training and requires individuals to learn on the job or to learn-by-doing (van Rooyen, 2007). In general, community-based workers are trained in areas of community development rather than being extensively trained in disability and rehabilitation (van Rooyen, 2007). Given that these workers receive less intensive training than professionals, employing community-based workers is less expensive (Chappell & Johannsmeier, 2009; Thomson, 2016; Walker & Jan, 2005).

Professionals.

There are a broad range of professionals who implement disability related services, but this section focuses on occupational therapists because of their relevance to this dissertation.

Professionals such as occupational therapists are extensively trained in disability and rehabilitation (Ataguba et al., 2012). Although disability is not synonymous with illness, some persons with disabilities require specialist professional intervention such as medical doctors or rehabilitation therapists (National Department of Health, 2015).

In South Africa rehabilitation therapists (occupational therapists, physiotherapists and speech and language therapists) are considered professionals and are required to register with the Health Professionals Council of South Africa (HPCSA) in order to practice. The Department of Health (2015) defines occupational therapy as a treatment aiming to facilitate individuals achieving independence in their own lives.

Professionals, such as occupational therapists, are often responsible for oversight functions for CBR interventions, such as managing CBR programmes, supervising personnel, receiving referrals and referring to other professionals (Finkenflügel & Rule, 2008). They also provide specialist rehabilitation services, and it has been suggested rehabilitation therapists could evaluate programmes (Finkenflügel & Rule, 2008). Specialist interventions consist of more specialised services, including but not limited to working with neuropsychological deficits, sensory

function and interpersonal skills. These are implemented either in institutional settings or in the community (National Department of Health, 2015).

Due to the shortage of human resources specifically amongst health care professionals, many community-based workers have recently taken on roles and responsibilities traditionally associated with professionals (Mannan et al., 2013). This is referred to as task-shifting (Finkenflügel & Rule, 2008).

Task-Shifting in CBR.

One of the goals of CBR programmes is to transfer skills and knowledge to community members (Ataguba et al., 2012). Task-shifting is when certain tasks and skills traditionally associated with highly-skilled professionals are delegated to less skilled persons, such as community-based workers or lay persons (Ataguba et al., 2012; Dawad & Jobson, 2011).

Due to the shortage of professionals and the fact that in South Africa, available professionals are concentrated in wealthy suburban areas, task-shifting to community-based workers from marginalised populations is key to making rehabilitative services available to more of the population (Ataguba et al., 2012; Western Cape Government, 2014). Without this skills transfer, providing services to people with disabilities becomes the tasks of a small number of skilled professionals and unprepared members of the community (Boyce & Ballantyne, 2000).

Some authors have criticised task-shifting as a possible risk to the quality of treatment (Ataguba et al., 2012; Clark, 2015; Dawad & Jobson, 2011). In recognition of this criticism, the WHO recommends that task-shifting be done under supervision, and that service providers allocate adequate support to both community-based workers as well as programme beneficiaries (Dawad & Jobson, 2011; WHO, 2007).

The above section described CBR and the roles of those who implement CBR programmes. This dissertation evaluates programmes focused on inclusive education and vocational rehabilitation programmes, thus the following section provides the reader with some context for programmes of this nature.

Context for South African Inclusive Education Programmes

Two of the programme components being evaluated here are inclusive education programmes. These programmes are educational programmes (CBR Matrix, Figure 3, page 28) and are therefore affected by the educational context.

Traditionally, learners with disabilities attended school separately from students without disabilities (Department of Education, 2001). More recently, South Africa introduced an inclusive education system, whereby learners with special needs and disabilities attend mainstream schools wherever possible (Department of Education, 2001).

The policy informing South Africa's strategy for Inclusive Education is laid out in the *Education White Paper 6: Special Needs Education: Building an Inclusive Education and Training System* (Department of Education, 2001). This policy calls for a shift from the medical model to the social model (Struthers, 2005). The medical model is based on the belief that a person's impairment is their disability, as such the best assumed response to disability is medical intervention (Mji et al., 2013). Whereas the social model of disability views disability as a human rights issue, occurring when attitudinal and physical barriers in society limit peoples' meaningful participation (Mji et al., 2013). Implementing the social model involves both ideological and practical changes (Department of Education, 2001). For example, when providing services for persons with disabilities, interventions should also service the institutions affecting those with disabilities, as well as servicing those who are in contact with persons with disabilities, such as family and community members (Department of Education, 2001). Therefore, the Education White Paper 6 (2001) acknowledges that a) all persons with disabilities, despite their abilities, are able to learn if they receive appropriate support and b) learning is compromised when the system does not accommodate the various needs of learners (Dalton, McKenzie, & Kahonde, 2012).

South Africa's legislation can be described as progressive in the commitment outlined in these documents to realising the principles set forward in the UNCRPD (2006), such as access to inclusive education at all levels. Despite these progressive strategies and policies, mainstream schools in South Africa continue to face barriers to inclusion (Pather, 2011). Where individuals have successfully been included in classrooms, teachers displayed positive attitudes and there was collaboration between teachers, parents and professionals (Engelbrecht et al, 2002; Pather, 2015). The reality for most schools in under-resourced areas, however, is that teachers are often overwhelmed and poorly equipped. This is further exacerbated by the additional needs of children with disabilities and special-needs (Pather, 2015). Usually, there is little or no contact with professionals such as occupational therapists, physiotherapists, or speech and language therapists (Pather, 2011). In addition,

large classrooms and a lack of collaboration between parents, teachers and professionals makes it difficult for teachers to implement inclusive education (Pather, 2011).

South African schools need to strengthen their capacity in order to be inclusive (Dalton et al., 2012; Pather, 2011). Research shows that two of the most influential factors in child development are the home environment and the child's experiences at school (Halgunseth, 2009; Xu & Filler, 2008). As such, to support and strengthen inclusive education in South African classrooms, the state has mandated that interventions engage not only learners with disabilities, but also their families, teachers, and school systems (Department of Social Development, 2016; Struthers, 2005).

Context for Vocational Rehabilitation Programmes

Vocational rehabilitation is a strategy to support employment for persons with disabilities (Coetzee, Goliath, van der Westerhuizen, & Van Niekerk, 2011). According to the South African National Department of Health, vocational rehabilitation programmes are:

> *"Programmes designed to restore or develop the capabilities of people with disabilities to secure, retain and advance in suitable employment."*
>
> (National Department of Health, 2015, p. 24)

The process of vocational rehabilitation involves working with personal attributes and behaviours as well as environmental factors to facilitate a variety of outcomes related to agency, self-determination, employment and social inclusion (Fleming, Del Valle, Kim, & Leahy, 2013; Walker et al., 2011). These interventions differ substantially from context to context in terms of the activities used, and are dependent on the needs of beneficiaries (Fleming et al., 2013). Thus, vocational rehabilitation approaches may take the form of vocational training, vocational guidance, sheltered employment or mainstream employment placement and support (Coetzee et al., 2011).

Legislation drafted prior to South Africa's democracy was not as progressive as more recent legislation, specifically with reference to protecting or promoting employment equity for persons with disabilities (Buys, 2015). The Employment Equity Act (1998) was the first piece of legislation to address disability in the workplace (Buys, 2015). The South African government recognises the need for the development of the

skills of persons with disabilities and acknowledges these individuals' rights to employment (Department of Social Development, 2016).

To realise this need, South African government has developed subsidy schemes which aim to facilitate persons with disabilities finding meaningful employment , as well as to increase the employability of these individuals though working with partners (such as NPOs) and placing individuals in sheltered workshops. One example of this kind of effort is the Framework on Subsidy Schemes for persons with disabilities developed by the Department of Labour. Additionally, the South African Department of Social Development has a policy on psychosocial support services which allows for the provision of financial incentives to partner organisations placing individuals with intellectual disabilities in protective workshops.

The role of CBR interventions operating in the livelihood domain is to provide people with disabilities with skills development, employment opportunities, and to facilitate community and social participation (WHO et al., 2010). Social inclusion and participation are concepts embedded in South Africa's policy and legislation. These principles are central to CBR interventions (Dawad & Jobson, 2011; van Rooyen, 2007). It is evident, however, that many people, particularly those with intellectual disabilities, face social and economic exclusion (McVilly, Stancliffe, Parmenter, & Burton-Smith, 2006).

Exclusion can occur either because of how individuals perceive themselves (self-exclusion) or because of how others perceive them (Coetzee et al., 2011; Finkenflügel & Rule, 2008). Social science literature states that social inclusion is not simply being physically part of a community. Social inclusion occurs when individuals are connected to others and participate meaningfully in community, economic and social activities (Abbott & McConkey, 2006; King, Baldwin, Currie, & Evans, 2005). The effects of social exclusion reach beyond the individual, as being socially excluded negatively impacts individuals' abilities to contribute to the economy (Wilson, Jaques, Johnson, & Brotherton, 2017). One way in which vocational rehabilitation programmes aim to combat social exclusion is through providing opportunities for disabled people to form social ties with peers (Wilson et al., 2017).

This chapter provided contextual information about CBR, service delivery mechanisms, and overviewed two different sectors, the inclusive education sector and vocational rehabilitation. In summary, despite informing South Africa's national approach to disability and rehabilitation, evidence on the efficacy of CBR is mixed and often hampered by poor research design. However, based on the available studies, there is evidence for CBR having positive effects on beneficiaries. There are various implementers of CBR programmes, the evaluator focused on community-based workers and occupational therapists. Due to the move away from the medical model, and because of the human resources shortage, there has been an increase in the use of community-based workers to implement CBR interventions.

In South Africa, inclusive education legislation requires that programmes offering education support are comprehensive and capacitate key role-players to better achieve desired outcomes for children in the education system. In order tocombat social and economic exclusion, vocational rehabilitation programmes aim to facilitate employment and enable the participation of individuals with disabilities in social life.

The next chapter details this evaluation's methodology.

Chapter 3: Method

This chapter outlines the methodology used to answer the evaluation questions identified in Chapter 1. The chapter starts by outlining the research and evaluation design, and then describes the procedure for data collection and analysis for Phases 1 and 2 of this dissertation.

Phase 1: Programme Theory Evaluation

This phase of the evaluation was conducted first and responds to the following evaluation questions:

1) What are the programme theories for the Inclusive Education Programme and the Vocation and Rehabilitation Programme?

   a) Are these theories plausible?

A note on theory and plausibility.

The author is aware of the potential confusion with the use of term 'theory' as there are multiple uses of the term. In this paper there are two uses for the term 'theory'. The most common use is that of programme theory, which refers to the theories embedded within the programmes under discussion. Other authors may describe these as models. A programme theory may be as simple as 'positive exposure to persons with disability will reduce stigma', this is a theory about what outcomes will be created by a particular behaviour. At other points in this document, social science theory is discussed. Here theory is used in the classical, academic, sense of the term.

Plausibility refers to evaluating how plausible or viable a programme theory may be (Funnell & Rogers, 2011). Once a programme theory has been made explicit the evaluator uses existing social science literature, a comparison of similar programmes and a logic and reasoning test to assess the plausibility of a programme theory.

Evaluation approach.

For the first phase, the evaluator used Donaldson's (2007) Theory Driven Evaluation Approach to evaluate two of CC's therapy-driven programmes. Theory evaluations investigate the underlying logic and implicit assumptions in a programme

(Funnell & Rogers, 2011; Rossi, Lipsey & Freeman, 2004). Programme theories help users to understand how the programme's activities (actions taken by programme staff) will bring about the intended outcomes (Rossi, et al., 2004). Once a programme's theory has been elicited from programme staff, the programme's activities are assessed against their intended outcomes (Funnel & Rogers, 2011; Rossi et al., 2004).

Donaldson (2007) suggests the following steps be taken to elicit a programme's theory: engaging stakeholders; developing the first draft; presenting the first draft to stakeholders; checking the plausibility of the theory using social science research and literature and, lastly, presenting the final model. These steps were followed for both of the therapy-driven programmes outlined below. It is worth noting that although there are two therapy-driven programmes, three theories were elicited as the Inclusive Education Programme has two separate components.

Step 1: Engaging stakeholders.

The evaluator, with input from CC's director, identified the stakeholders for each programme and programme component. The director, board members and implementing staff of CC's therapy-driven programmes were invited to focus groups, where the programme theories were elicited by the evaluator together with the programme staff. The director and board members were asked to participate due to their knowledge of and involvement with the programmes. The implementing staff were also asked to participate, as they are exposed to the realities of implementing the programmes, making them able to provide the evaluator with valuable context-specific knowledge (Oosthuizen & Louw, 2013). Table 2, below, shows the numbers of participants who agreed to participate in Phase 1 of this dissertation.

Table 2

Participants for Phase 1: Programme Theory Evaluation for Chaeli Campaign's Therapy-Driven Programmes

	Classroom component	Parent component	Vocation and Rehabilitation Programme
Stakeholder group	Frequency	Frequency	Frequency
CC implementing staff	4	4	1
CC programme facilitators	0	0	10
Total	4	4	11

Step 2: Development of first draft of the programme theories.

Chen (2005) suggests using both forward and backward reasoning in extracting programme theories from stakeholders. Forward reasoning starts with identifying the activities and then based on those, projecting forward to the outcomes. Whereas backwards reasoning starts with identifying outcomes and logically working backwards to what the necessary components need to be to achieve those outcomes (Chen, 2005). The evaluator used both forward and backward reasoning to guide the discussion during the focus groups. The evaluator posed specific questions in order to elicit programme activities, outcomes and other components of the programme theory. For example, one question asked during the focus groups was:

"*What are the activities of the programme? If I were a beneficiary, what process would I go through for this programme?"*

The evaluator, together with the participants, mapped out the activities and outcomes of each programme, then the causal mechanisms between the various components were discussed. Questions such as "*What is the immediate result of this activity?"* were asked.

This was repeated until all needs, activities and outcomes were mapped out as a logic model. A logic model is a typical way of representing a programme's theory in programme evaluation.

Prior to starting Step 2, all participates were required to sign a consent form. This form can be found in Appendix B.

Step 3: Present first draft.

A first draft of the model for each of the programme theories, developed during steps 1 and 2, was emailed to the stakeholders, listed in Table 2 (page 41). They were requested to review the draft of the programme theory and confirm that it portrayed an accurate reflection of the programme's theory.

Stakeholders were given the opportunity to propose changes via email. Three participants responded to the email for each programme (one from each of the programmes or programme components). The feedback forms for each programme can be found in Appendices C1, C2 and C3. Once the stakeholders had validated each of the programme theories, the evaluator checked the plausibility of the underlying logic of each, in Step 4.

Step 4: Plausibility check.

Literature on comparable programmes was reviewed to establish the feasibility of CC's programme theories. Appendix D documents the search strategy and criteria for inclusion used to find publications on programmes that are comparable to CC's therapy-driven programmes.

The evaluator collected information from the literature on: a) activities used by similar programmes; b) outcomes documented by these programmes, and c) which activities were associated with which outcomes in comparable programmes. Given the broad range of activities and outcomes found in the literature, the evaluator re-classified specific activities and outcomes into broader categories of activities and outcomes. This allowed for easier cross-programme comparisons.

Publications on programmes were considered eligible for inclusion if these publications: a) were published within the previous 20 years, b) were programme theory evaluations; outcome evaluations; process evaluations; impact evaluations; cost-effectiveness studies, or studies documenting programme activities and outcomes, c) shared similar programme goals, d) were implemented in similar contexts and / or e) targeting similar beneficiaries.

Using the information gathered in Step 4, the evaluator made a judgement regarding the plausibility of each model. This is outlined in the Results in Chapter 4.

Step 5: Final model.

In a final meeting, the evaluator provided recommendations to CC's staff and the final programme theory diagram for each programme was made available to CC for their use.

Phase 2: Multi-Criteria Decision Analysis using the Analytic Hierarchy Process

The approach used for this part of the evaluation is outlined below.

Evaluation approach.

Multi-criteria decision analysis (MCDA) is an umbrella term for a group of decision-making methodologies (Dodgson, Spackman, Pearman & Philipps, 2009). MCDAs are used to make decisions and make explicit the reasons for making a certain decision (Dodgson, et al., 2009).

This evaluation consists of three MCDAs using the Analytic Hierarchy Process (AHP) technique, one for each of the two therapy-driven programmes (one for the

parent and one for the classroom components of the Inclusive Education Programme and one for the Vocation and Rehabilitation Programme).

To provide the reader with an overview of MCDAs, this section starts out by explaining why decision-making methodologies are required, followed by a brief summary of how MCDAs work, and concludes by outlining the technical procedure for conducting MCDAs.

Why decision-making methodologies are required.

Making organisational decisions involves collecting information, evaluating that information, and assessing trade-offs (Saaty & Niemira, 2006). Many authors have noted that decision-making is by its nature a complex process (Dolan, 2000; Hummel, Bridges, & IJzerman, 2014; Marsh et al., 2016; Mu & Pereyra-Rojas, 2017). Some reasons for the complexity of making decisions are that: a) there are often multiple, conflicting options to consider; b) information used to make decisions can be incomplete or imperfect, and c) when multiple decision-makers are involved, there are different perspectives and motives to be considered (Dodgson et al., 2009; Dolan, 2000).

For these reasons, it is useful to use decision-making methodologies. Decision-making methodologies are structured frameworks, which aim to simplify the decision-making process, and make the process explicit. This enables users to document and justify their reasons for choosing one alternative over another (Marsh et al., 2016).

The fundamentals of how MCDAs work.

An MCDA works by organising a decision into its constituent elements in the form of a hierarchy. Each decision is broken down into: the decision's goal, the options (alternatives) and criteria by which these alternatives are judged (Saaty, 2001).

CC's problem statement prescribed the goal for each of the three MCDAs: the goal was deciding on the most preferred worker to implement the therapy-driven programmes. In order to make this decision, a set of deciding criteria were developed. The criteria are the standards against which the alternatives are judged. For example, in CC's case there are two alternatives, a community worker or an occupational therapist. To decide on which implementer is preferred, one may consider

implementation costs, an implementer's qualification and an implementer's ability to develop skills in pre-schoolers as a set of criteria.

Figure 4 shows how a decision is structured into its constituent elements in the form of a hierarchy.

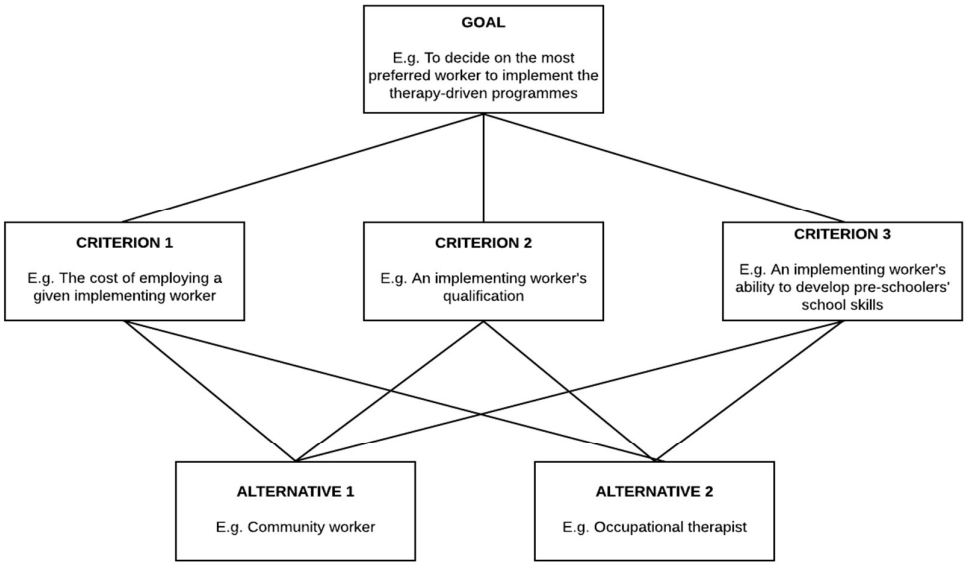

Figure 4. Example multi-criteria decision analysis format.

This evaluation used the AHP technique to implement the MCDAs. Given that CC's programmes have multiple stakeholders, there were multiple participants in the MCDAs. These types of MCDAs are known as group-based MCDAs.

Using the decision model to implement group-based MCDAs using the AHP technique.

AHP is a form of MCDA that utilises pairwise comparisons to establish a) which criteria are most important and should be weighted as such, and b) which alternative is most preferred (Mu & Pereyra-Rojas, 2017).

In the AHP technique, the Decision Makers (DMs) are each presented with two criteria at a time (pairwise comparison). From these criteria, a DM chooses which criterion is most important and to what extent the chosen criterion is more important. Once all criteria have been compared with each other, the DMs are presented with

two alternatives at a time. For each pairwise comparison of alternatives, one criterion is presented. DMs are then asked which alternative they prefer, and to what extent they prefer the dominant alternative, in relation to a single criterion. This is repeated until all alternatives have been compared with one another and until all criteria are exhausted.

In general, criteria are measured on different scales, which makes decision-making complicated, but the AHP technique standardises criteria by creating a new scale by which all criteria, and alternatives, can be compared (Saaty, 2001). Thus, one strength of the AHP technique is that both tangible and intangible criteria can be assessed (Mu & Pereyra-Rojas, 2017).

Overview of conducting group-based MCDAs using AHP.

The evaluator had to do the MCDAs in three stages for each of the three MCDAs. For the first phase, MCDAs were conducted for each individual DM, these scores were then aggregated. The evaluator then conducted an MCDA for each stakeholder group to view differences between groups. Lastly, to obtain the results reported on in this dissertation, the evaluator used the aggregate scores (obtained in the first phase) for all stakeholders and conducted an MCDA for all the stakeholders for each of the three MCDAs. Figure 5 below shows these three phases.

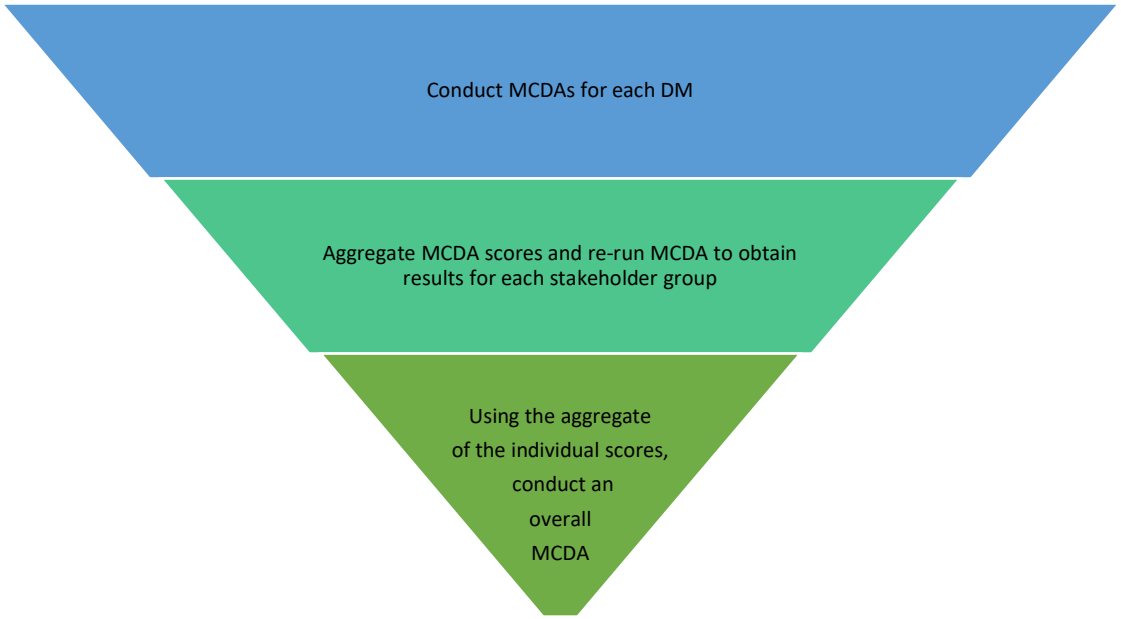

Figure 5. Stages of conducting multi-criteria decision analyses for Chaeli Campaign.

Technical procedure.

The literature on MCDA using the AHP technique offers guidance on how to effectively conduct an MCDA. The following sections outline the procedural steps for AHP analyses, adapted to be suitable to group decision making by Mu and Pereyra-Rojas (2017). The steps of a group AHP procedure are:

- Preparing for analysis: Identifying DMs
- Step One: Constructing Decision Models
- Step Two: Eliciting DMs' Judgements
- Step Three: Establishing Criteria Weights and Checking Consistency
- Step Four: Establishing Local Priorities for Alternatives
- Step Five: Aggregating Judgements
- Step Six: Model Synthesis
- Step Seven: Sensitivity Analysis.

Preparation for analysis: Identifying DMs.

Before starting the analysis, it was important for the evaluator to identify DMs who would serve as data providers in the MCDAs. The literature does not give definitive guidelines on who should be included as DMs but does suggest that ideally, in group decision making, stakeholders who will be affected in some way by the decision being made should be included in the analysis (Marsh et al., 2016).

DMs were identified by the evaluator if they met one or more of the following criteria: a) persons with a strong association to the programmes (those who are affected by them); b) persons with intimate knowledge of the programmes at CC; c) persons with expert knowledge of similar programmes, or d) persons with considerable investment in the success of the programmes. Based on these four criteria, the evaluator decided that the DMs should be divided into the following: 1) CC's beneficiaries, 2) CC implementing staff, 3) disability experts, and 4) current programme funders. Table 3 provides further details on these stakeholder groups.

Table 3

Rationale for the Inclusion of Each Stakeholder Group in the Multi-Criteria Decision Analyses

Stakeholder group	Reason for including the decision-maker / stakeholder
CC's beneficiaries	• Persons with considerable investment in the success of the programmes • Persons with a strong association to the programmes • Persons with intimate knowledge of the programmes at CC
CC's implementing staff and director	• Persons with considerable investment in the success of the programmes • Persons with intimate knowledge of the programmes at CC • Persons with a strong association to the programmes
Disability expert	• Persons with expert knowledge of similar programmes
Current funders / current donors	• Persons with considerable investment in the success of the programmes

All programme staff and current donors were invited to participate, and CC allowed any non-disabled beneficiaries to participate. Disability experts were selected from the University of Cape Town. Stakeholders were contacted via email and asked to participate in the MCDA. Respondents who agreed to participate in the MCDAs can be seen in Table 4.

Table 4

Respondents for Phase 2: Multi-Criteria Decision Analyses for the Therapy-Driven Programmes

	Classroom component	Parent component	Vocation and Rehabilitation Programme
Stakeholder group	Frequency	Frequency	Frequency
CC beneficiaries	1 (teacher)	2 (parents)	0
CC implementing staff / director / volunteer facilitators	2 (staff)	2 (staff)	4 (2 staff, 2 facilitators)
Disability expert	1	1	1
Potential funder/donor	1	1	0
Total	5 DMs	6 DMs	5 DMs

The Vocational and Rehabilitation Programme's beneficiaries are young adults with disabilities (YAwD). As seen in Table 4, YAwD were not included as DMs for the MCDA of the Vocation and Rehabilitation Programme. Initially, the evaluator designed the evaluation with the intention to include YAwD as DMs. CC's staff, however, felt it was best to not include this stakeholder group given the high prevalence of intellectual disability amongst the beneficiaries. It was agreed that the facilitators (most of whom were care givers of beneficiaries) would be included in the analysis instead of the programme beneficiaries. The evaluator contacted all current funders of the Vocation and Rehabilitation Programme, none responded and thus no funders were included in the MCDA for this programme.

Step One: Constructing decision models.

The first step is to break the decision into its constituent parts as depicted in Figure 4 (page 45). CC's question was to establish: whether an occupational therapist or a community worker is the most preferred alternative to implement the Vocation and Rehabilitation Programme and the two components of the Inclusive Education Programme and. These two implementers make up the alternatives for each of the MCDAs.

In order to make this choice, however, the DMs needed to be presented with a list of criteria against which they could assess each alternative.

The criteria used for each programme.

Criteria are an important part of any MCDA and are typically developed by the evaluator (Marsh et al., 2016; Mu & Pereyra-Rojas, 2017). Therefore, this section focuses on how criteria were developed.

In order to make a valid judgement as to which alternative is more appropriate in achieving the programme's aim, the criteria need to reflect all relevant considerations of the programme (Marsh et al., 2016). Thus, the evaluator decided that the criteria should be drawn from intended programme outcomes, programme goals, literature on the topic and the practicalities of implementing these programmes.

Programme outcomes are indicators of whether a programme is implemented as planned, thus, the evaluator reviewed the programme theories and selected an outcome for each programme activity as a criterion in the MCDA. Most activities have multiple outcomes linked to them, these could not all be included. Therefore, the evaluator selected either the longest-term outcome for an activity, or the outcome which best summed up what that activity was trying to achieve.

In order to ensure that criteria were aligned with the programmes' wider objectives, the evaluator reviewed each programme objective (provided by CC's director) and incorporated these into criteria as well.

Social science literature was also reviewed to find goals for similar programmes. This aligned CC's programme criteria with the wider literature.

Programme practicalities were considered by the evaluator. Programme practicalities were factors that form part of the ongoing running of the programme, for example, the cost incurred by the organisation for either an occupational therapist or a community worker.

Lastly, the evaluator consulted several experts in disability and rehabilitation to review the programme criteria and asked these experts whether these criteria were comprehensive.

Step Two: Eliciting judgements.

Once the decision hierarchy had been created, the second step in the MCDA process was for the DMs to weight / rank each of the criteria. To do this, the evaluator asked the DM's which criteria they viewed as the most important.

Criteria were presented to DMs in a pairwise fashion. For example, *criterion a* is compared with *criterion b, criterion a* with *criterion c* and so on, until all the criteria had been compared with each other. For each pairwise comparison of criteria, DMs were asked whether, for example, *criterion a* is more important, less important, or equally important when compared to *criterion b*. As an illustrative example, using the criteria from Figure 4 (page 45), DMs would be asked the following:

When selecting an implementer for the programme, which is more important, an implementers' qualification or their ability to develop pre-schoolers' skills?

The above question would be accompanied by Saaty's (2012) numeric scale. Saaty's scale (2012) was used by DMs to indicate the degree to which criterion is more) less or equally important, when compared to another criterion. This scale consists of verbal statements accompanied by numeric values, from the values one to nine (where one represents that criteria are equally important and nine indicates a certain criterion is fundamentally more important than another). Table 5 shows Saaty's numeric scale (2012).

Table 5

Saaty's Numeric Scale (2012) Adapted from Hummel, Bridges, & Ijzerman, 2014 (p. 113)

Verbal Judgement	Numeric Value
Extremely important / preferred	9
	8
Very strongly more important / preferred	7
	6
Strongly more important / preferred	5
	4
Moderately more important / preferred	3
	2
Equally important / preferred	1

In order for the evaluator to obtain the required data, DMs completed a questionnaire which was set up using Qualtrics[5]. One questionnaire was set up for each of the programmes. The covering page of the questionnaire contained a consent form.

Firstly, to distinguish which criterion was viewed as most important, the DMs were presented with pairwise criteria in the questionnaire. For example, a DM was shown Criterion 1 versus Criterion 3 and was asked to rate which of the two is more important. See Figure 6 [6].

Figure 6. Example questionnaire question for weighting criteria[7].

A number of pairwise comparisons were shown to each DM until they had rated all criteria against one another.

To distinguish which of the two implementers (occupational therapist versus community worker) was preferred for each of the programme criteria DMs were presented with pairwise comparisons asking which of the alternatives DMs preferred in relation to each criterion.

Saaty's scale (2012) is used to determine the extent of preference. This was repeated until all the alternatives had been compared and all criteria were exhausted. For example, a DM was shown Alternative 1 versus Alternative 2 and asked to rate which of the two is more preferred. See Figure 7.

[5] Qualtrics is specialised software for developing questionnaires.

[6] It is customary to display Saaty's (2012) scale as seen in Figures 6 and 7.

[7] It is worth noting that DMs could indicate that both alternatives are equally preferred by selecting a value of 1 on Saaty's (2012) scale.

Figure 7. Example questionnaire question for preferences for alternatives.

A number of pairwise comparisons were shown to each DM until they had rated each of the alternatives against one another.

The evaluator entered the judgements for pairwise comparisons of a) criteria and b) alternatives, into comparison matrices using Super Decisions v2[8] (Super Decisions).

Super Decisions stores this data in a comparison matrix. A comparison matrix is used to display the pairwise judgements in a way that allows for easier analysis. To best describe a comparison matrix and how it was used in this evaluation, an illustrative example of a comparison matrix is provided as Table 6.

Table 6

Illustrative Example of a Comparison Matrix Used in the Analytical Hierarchy Process

	Criterion 1	Criterion 2	Criterion 3
Criterion 1			6
Criterion 2			
Criterion 3	1/6		

As seen in Table 6, criteria are listed in blue on the left, and red on the right, the colour coding is part of AHP conventions and is meant to reduce confusion when working with comparison matrices. Usually all cells of a comparison matrix contain numeric values but for simplicity the illustrative example only contains two values, in the top right and bottom left cells.

[8] Super Decisions v2 is the AHP software used to conduct and analyse the MCDAs. See Appendix E for an overview of Super Decisions v2.

The top right cell, where Criterion 1 and Criterion 3 are compared against one another has a value of 6. This is the hypothetical judgement a DM would have made when asked whether Criterion 1 or Criterion 3 is more important.

The value of 6 means that the DM believes Criterion 3 is 6 times more important than Criterion 1 (according to Saaty's (2012) scale).

There are a number of cells in grey, one containing the value of 1/6 (indicating that because Criterion 3 is more important than Criterion 1, Criterion 1 is less important than Criterion 3) these cells can be disregarded as they do not reflect actual judgements of DMs. They contain values which are generated automatically by the Super Decisions software. These values are based on Saaty's (2012) scale and indicate the mathematical opposite for each of the values chosen by the respondent – displayed in the white cells. They are used to calculate consistency which is discussed on page 55.

An additional piece was added to the questionnaire, this third part was optional and is not traditionally part of an MCDA. It consisted of qualitative feedback where DMs could explain the responses they had given in parts one and two.

All DMs, except for the beneficiaries of the classroom and parent components of the Inclusive Education Programme, were contacted via email containing a link to the online questionnaire. CC was under the impression that, given the low literacy and education levels of some beneficiaries of the Inclusive Education Programme components, they may have difficulty in completing the questionnaires. Thus, the evaluator met with beneficiaries in person to administer questionnaires.

Once DMs had consented to participate, and after having completed the questionnaire, responses were submitted to the evaluator either electronically via Qualtrics or by hand. The questionnaires are attached as Appendices F, G and H, the classroom component of the Inclusive Education Programme, the parent component of the Inclusive Education Programme and the Vocation and Rehabilitation Programme, respectively.

Step Three: Establishing criteria weighs and checking consistency.

The next step was to obtain weights for the criteria.

Calculating criteria weights.

Data from Qualtrics was captured in Super Decisions, the AHP software programme that automatically calculates criteria weights and checks for inconsistencies in judgements.

Saaty recommends using the principal right eigenvector approach to weighting criteria (Saaty, 2003). This is a simple standardisation process, and results in the most important criteria having the highest weights (Saaty, 2003). Super Decisions automatically calculates weights and normalises the scores on each criterion to add up to the value of 1 (Hummel et al., 2014). For analyses with sub-criteria, each sub criterion adds up to the weight of the covering criterion (Hummel et al., 2014).

Consistency check.

Given that the judgements elicited are subjective, some of the judgements may be inconsistent, meaning the DM's logic in judgements is imperfect (Saaty, 2001). Inconsistency refers to the degree to which DMs contradict themselves in assigning weights or preferences to criteria or alternatives. Thus, consistency indicates that a DM's logic in assigning weights or preferences is rational.

It is not reasonable to expect perfect consistency from subjective participants, as such the AHP technique allows for some inconsistencies in judgements (Saaty, 2001). In order for results to be considered valid they must be below what is known as a consistency ratio (CR).

The CR is calculated automatically by Super Decisions (Mu & Pereyra-Rojas, 2017). The CR shows the degree to which judgements entered resemble a randomly-entered comparison matrix (see Table 6, page 53) (Hummel et al., 2014; Mu & Pereyra-Rojas, 2017). If this CR is above 0,10, it would indicate that the inconsistency in judgements is too high to continue the analysis (Saaty, 2001).

In such an event, Super Decisions automatically identifies the sources of the inconsistencies for each individual DM, that is, the judgements which are most inconsistent. The evaluator then adjusts these judgements to reduce the inconsistencies (Mu & Pereyra-Rojas, 2017). According to conventions on AHP, this adjustment is done by reducing the numeric value assigned to the dominant criterion, in so doing the degree to which a criterion is prioritised is reduced. Guidelines suggest that the evaluator reduces the DM's judgement to a value of 2 (Mu & Pereyra-Rojas,

2017). The evaluator adjusts judgements in this way until the overall CR value is below 0,10 (Saaty, 2001).

Step Four: Establishing local priorities for alternatives and checking consistency.

The overall aim of this step is to calculate priorities for the alternatives (termed local priorities) this is done by considering the results, as they indicate the degree to which each alternative is preferred. As with the criteria weighting in step three, this step utilises the data from the pairwise comparisons and Saaty's scale (2012) (Saaty, 2001).

Super Decisions automatically calculates the priorities for alternatives through an additive and multiplicative process whereby the scores for each alternative on a criterion are summed and multiplied by the weight of that criterion (Hummel et al., 2014; Saaty, 2001). After this a second consistency check is performed, using the same procedure described above.

Step Five: Group aggregation.

From the above steps, the evaluator obtained the MCDA results for each DM, however, these needed to be pooled and aggregated to obtain the overall result. i.e. the final result that accounts for all of the responses.

To obtain the views of each stakeholder group as opposed to each DM, the evaluator used Microsoft Excel's GEOMEAN function to find the geometric mean for each judgement for all of the DMs within a stakeholder group. The geometric mean is calculated by solving for the product of all values under consideration (Mu & Pereyra-Rojas, 2017).

Following this, steps two to four were repeated with scores representing stakeholder groups rather than individuals. In so doing, the evaluator obtained the data required to synthesise the AHP models.

Step Six: Model synthesis.

The previous steps: a) derived weights for the criteria, b) derived preferences for alternatives and c) aggregated the judgements. The aim of this step is to synthesise the results, by ranking the alternatives according to their importance while taking into account that each criterion has a weight assigned to it. This results in an overall score indicating which is the preferred implementer (termed an overall priority) (Saaty, 2001).

Super Decisions automatically calculates the overall priorities by summing each local priority for each alternative (Saaty, 2001). These are used to rank both the relative and absolute importance of each alternative (Saaty, 2001). Although this is not the last step of an MCDA, the results from this step are used as the output of the MCDA, which are then analysed. It is also necessary, though, to test how sensitive the results are.

Step Seven: Sensitivity analysis.

Mu and Pereyra-Rojas (2017) describe sensitivity analysis as a "what-if analysis" (p. 20). This analysis establishes how the output from step six would differ if all criteria were weighted differently. It is important to do this to enable evaluator to establish how the weighting of the criteria influences the final overall priority of an MCDA. As such, the sensitivity analysis answers the following question: *would the results from step six be maintained even if criteria were weighted differently?* (Saaty, 2001). This allows MCDA users to establish how strong, or to what degree, the chosen alternative is preferred.

One technique is to assign equal weightings to all criteria and to then re-run the analysis to see how the results differ (Mu & Pereyra-Rojas, 2017). To do this, each criterion's local priority is adjusted by dividing by the total number of criteria in a model (Mu & Pereyra-Rojas, 2017). Thereafter the model is synthesised as described above in Model Synthesis.

This chapter has outlined in detail the methodology used for this research project. The next chapter presents the results obtained.

Chapter 4: Results

The results chapter is divided into two sections, first is the programme theory evaluation and second are the results for the MCDAs.

Results for the Programme Theory Component (Phase 1)

The theory component, Phase 1, of this dissertation consisted of eliciting programme theories for two programmes; the Inclusive Education Programme (consisting of two components and thus two programme theories) and the Vocation and Rehabilitation Programme. An overview of each programme theory is presented below, followed by programme theory diagrams. The results for the plausibility of each programme are also presented.

The evaluator assessed plausibility in three steps. First, the evaluator assessed whether the activities used by CC are found in other programmes. Then the evaluator assessed whether CC's intended outcomes are comparable to those used by similar programmes. The reasoning here is that if CC's activities and intended outcomes are similar to activities and outcomes used by other programmes in the field, then CC's actions and intended outcomes are appropriately designed to address the needs of their target beneficiaries.

To allow for comparisons across different programmes, the activities and outcomes of both CC's programmes as well as other programmes were re-classified into broader categories of activities and outcomes. In assessing CC's programmes, it was decided that activities and outcomes needed to be aligned with at least one other programme to be plausible. The final step was to assess not only whether activities and outcomes were aligned with other programmes, but whether it would be feasible to expect certain activities to lead to certain outcomes. To do this, the evaluator assessed whether other programmes made explicit that certain, similar, activities led to specific outcomes. If the majority of CC's causal linkages were documented in the literature, then one would be able to reasonably conclude that these were plausible (causal linkages refer to an action causing or leading to a particular outcome).

Classroom component of the Inclusive Education Programme.

This programme component offers education support to pre-schools in Masiphumelele. An occupational therapist, together with community workers, provide three sessions to a group of learners, each of which is implemented in ECD

classrooms. The first session has two parts. In the first part, an occupational therapist and community worker lead a series of activities that focus on developing fine-motor skills necessary for school readiness. This session consists of the occupational therapist teaching children how to correctly throw and catch balls; do exercises such as passing beanbags around; cut with scissors (using the thumbs up technique to ensure correct use of scissors), the first half of this session ends off with children building puzzles while the occupational therapists observes.

As these activities help develop fine motor-skills, school-related skills and because the therapist is there to address any incorrect use of classroom tools, CC believes that this session results in the intended short-term outcome of children gaining skills necessary for school. Having gained and practiced these skills, children will eventually reach the intended long-term outcome of school readiness.

The second part of the first session consists of the occupational therapist screening children for disabilities, this is done by observing how well children perform classroom activities. This contributes to the intended long-term outcome of identifying children with disabilities and development delay. Collectively, the two parts of the first session aim to address two needs: a) children with disabilities not being identified and b) a lack of school readiness amongst ECD-children.

The second session of the programme component focuses on normalising the way disability is perceived by children. To do this the implementers lead a discussion on disability, introducing what disability is, and talking about how it occurs. The implementers speak to children about how to be friends with children with disabilities. Children are also taught basic Sign language and have the opportunity to play with assistive devices. The various activities in this session provide children with: knowledge about disability; insight into what it may feel like not to see or to have to use an assistive device and enable children to better communicate with children with impairments (through learning Sign). These activities are intended to lead to the intended short-term outcomes, namely: gaining an understanding of what it feels like not to see, gaining an understanding of what it feels like to be in a wheelchair, learning about disabilities and learning basic communication skills (Sign Language). Having gained empathy, knowledge and communication skills, children may reach the intended medium-term outcome of coming up with their own ways to include children with disabilities in games. Additionally, the use of assistive devices is normalised, this is one of CC's medium-term outcomes. Collectively, these activities lead to the

programme's intended long-term outcome of children being less afraid of people with disabilities and better equipped to include children with disabilities.

The third session is aimed at teachers. The implementers discuss how to support children with disabilities or developmental delays. They also answer teachers' questions and discuss how to approach parents and set up referrals when required. This session is intended to lead to the short-term outcome of teachers gaining knowledge, which is the first step required for the eventual long-term outcome, that teachers are upskilled sufficiently to implement inclusive practises in their classrooms.

The programme theory for the classroom component of the Inclusive Education Programme can be seen in Figure 8. Figure 8 shows the programme's needs and activities linked to the short-term outcomes (termed STO in the programme theory diagram), medium-term outcomes (MTO) and long-term outcomes (LTO). Appendix I provides the first draft for this programme theory.

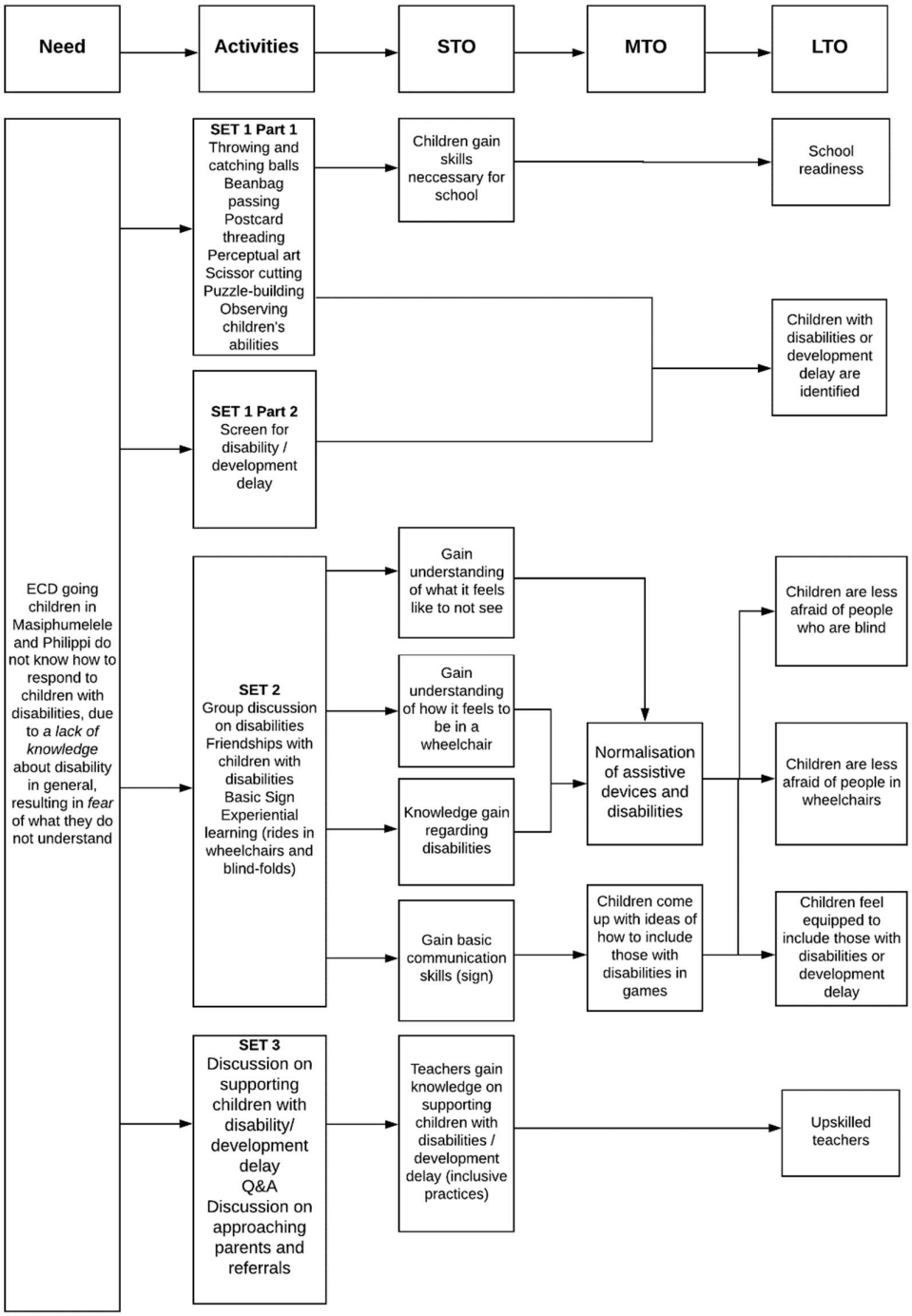

Figure 8. Programme theory for the classroom component of the Inclusive Education Programme.

The next section discusses the plausibility of the classroom component. The plausibility assessment is presented in three parts, first the evaluator reports on whether CC's activities are aligned to those of comparable programmes. Then the evaluator discusses the alignment of CC's intended outcomes. The activities and outcomes were classified broadly. After this the evaluator reports on the causal linkages of CC's programme theory and whether these are plausible.

The three parts of the plausibility assessments will be discussed in subsequent sections using tables to display the results. The tables (Tables 7;8;10;11,13, and 14) list the broad activities or outcomes in the first column, followed by indicating how many comparable programmes documented the use of each activity or outcome. The next column in each table provides a reference to the publication reviewed. The last column indicates whether CC included a similar activity or intended outcome in their programme theory.

Plausibility of the classroom component of the Inclusive Education Programme's programme theory.

In order to assess the plausibility of the logic of the classroom component of the Inclusive Education Programme, seven comparable programmes were identified in social science and evaluation literature.

From these seven programmes, the evaluator categorised activities into ten broad activity groups. Appendix I (Table I1) provides details on which of CC's activities fall into each category as well as describing the activities from other programmes.

Across the seven comparable programmes, two activities were found to be most common: a) disability-related talks and education and b) friendship-promoting stories, discussions or activities. CC included similar activities in this component of their programme. Table 7 documents these activities as well as other activities found in comparable programmes.

Table 7

Broad Activities for CC's Classroom Component of the Inclusive Education Programme and Comparable Programmes

Activity	Number of programmes (other than CC) including the activity	Reference to the publication	CC's inclusion of an activity
Activities teaching children how to use classroom tools	2	Rossi & Stuart, 2005;	Yes
Arts, music and story-telling	2	Rossi & Stuart, 2005; Sheppard, Osmond, & Stagnitti, 2013	Yes
Basic numeracy games/activities	1	Rossi & Stuart, 2005	No
Disability-related talks and education	3	Cameron & Rutland, 2006; de Boer, Pijl, Minnaert, & Post, 2014; Favazza, Phillipsen, & Kumar, 2000	Yes
Friendship-promoting stories / discussion / activities / contact intervention	3	Cameron & Rutland, 2006; Favazza et al., 2000; Rossi & Stuart, 2005	Yes
Gross-motor skills and co-ordination skills development	2	Rossi & Stuart, 2005; Sheppard et al., 2013	Yes
Information on development and health (aimed at teachers)	2	de Boer et al., 2014; Schepis et al., 2000	Yes
Language-based activities / Early literacy	2	Pears, Kim, Healey, Yoerger, & Fisher, 2015; Rossi & Stuart, 2005	No
Screening for disabilities/ development delay and ill health	0		Yes
Self-regulation activities	2	Pears et al., 2015; Sheppard et al., 2013	No

Note. Total number of programmes reviewed: 7.

Note. The highlighted row indicates which outcomes are the most common.

As seen in Table 7, screening for disabilities and development delay is the only activity of CC's not found in comparable programmes. The remainder of CC's activities are found in one or more comparable programme. Given that CC's activities in this programme component show a lot of similarities, both operationally and theoretically, with other programmes intended to create similar outcomes, it can be reasonably concluded the activities in this component are feasible.

To assess the feasibility of CC's outcomes, the same seven comparable programmes were reviewed. The outcomes described in these programmes were classified into eight broad outcomes. Table I2 in Appendix I documents how CC's outcomes and outcomes from other programmes were classified.

The outcomes found to be most common were: improved social skills of pre-schoolers and a change in attitudes towards children with disabilities. These outcomes are similar to the outcomes that CC intends to achieve. Table 8 documents these results. This table can be read in the same way as Table 7, however, outcomes replace activities in Table 8.

Table 8

Broad (Intended) Outcomes for CC's Classroom Component of the Inclusive Education Programme and Comparable Programmes

(Intended) Outcome	Number of programmes (other than CC) including the outcome	Reference to the publication	CC's inclusion of the intended outcome
Change in attitude towards children	3	Cameron & Rutland, 2006; De Boer et al., 2014; Favazza et al., 2000	Yes
Children gain understanding and empathy	0		Yes
Functional performance of school activities	2	Rossi & Stuart, 2005; Sheppard et al., 2013	Yes
Gain knowledge regarding disabilities (children)	0		Yes
Improved social skills	3	Pears et al., 2015; Rossi & Stuart, 2005; Sheppard et al., 2013	Yes
Pre-schooler's language skills developed	2	Pears et al., 2015; Sheppard et al., 2013	No
Self-regulatory Skills	2	Pears et al., 2015; Sheppard et al., 2013	No
Upskilled teachers	1	Schepis et al., 2000	Yes

Note. Total number of programmes reviewed = 7.

Note. The highlighted row indicates which outcomes are the most common.

As seen in Table 8, CC has two intended outcomes not seen in comparable programmes, namely, an increase in pre-schoolers' knowledge of disabilities and children gaining understanding and empathy for those with disabilities. However, the majority of CC's outcomes are aligned with similar outcomes of comparable programmes. Thus, in general, the intended outcomes included in CC's programme theory are feasible.

As a final step in establishing plausibility of this programme theory, the evaluator assessed whether specific activities have been found to lead to certain outcomes. In assessing the causal linkages of CC's activities and intended outcomes,

the evaluator found that CC's linkages (the logic behind how activities lead to outcomes) are aligned with other comparable programmes. CC uses activities similar to other programmes to develop the following intended outcomes: a) a change in attitude towards people with disabilities, b) improved performance of school activities, c) improved social skills and d) upskilled staff.

Table 9 documents these results by indicating the specific activities used to create intended outcomes by other programmes. The tables presenting the causal linkages show CC's intended outcomes in the first column, followed by listing activities (found in comparable programmes) used to develop similar outcomes. The last column lists the references to publications reviewed.

Table 9

CC's Causal Linkages for the Classroom Component of the Inclusive Education Programme Assessed Against Comparable Programmes

CC's intended outcomes	Activities used by comparable programmes to develop outcomes	Reference to publications
Change in attitude towards those with disabilities	Disability-related talks and education	Cameron & Rutland, 2006; Boer, Pijl, Minnaert, & Post, 2014
	Friendship-promoting stories / discussion / activities / contact intervention	Cameron & Rutland, 2006; Favazza et al., 2000; Rossi & Stuart, 2005
Functional performance of school activities	Activities using use classroom tools	Rossi & Stuart, 2005
	Gross-motor skills and co-ordination skills development	Sheppard et al., 2013
Improved social skills	Activities using use classroom tools	Rossi & Stuart, 2005; Sheppard et al., 2013
	Arts, music and story-telling	Rossi & Stuart, 2005; Sheppard et al. 2013
	Friendship-promoting stories / discussion / activities / contact intervention	Cameron & Rutland, 2006; Favazza et al., 2000; Rossi & Stuart, 2005
Upskilled staff	Information on impairments (aimed at teachers)	Schepis et al., 2000

Table 9 shows that programmes documented in the literature used various activities, similar to those of CC, to develop outcomes like CC's outcomes. Based on the analysis conducted in Table 9, CC's causal linkages are aligned with similar programmes' causal linkages and are thus plausible.

In summary, the classroom component of the Inclusive Education Programme is based on the theory that serviced pre-schools will be more inclusive and adequately prepare all children for school if CC's education support staff (occupational therapists and community worker) implement activities to:

a) enable children to become school ready,

b) enable children to be more inclusive, and

c) upskill teachers to be more inclusive.

This is because, according to CC, pre-schoolers are not being adequately prepared for school, and pre-schoolers and teachers lack knowledge about disability, meaning they are not as inclusive as they could be.

A plausibility assessment found alignment between the activities implemented and the intended outcomes. Given the plausibility of a) activities, b) outcomes and c) that the activities are plausibly linked to outcomes, the programme theory for the classroom component of the Inclusive Education Programme is plausible.

Parent component of the Inclusive Education Programme.

CC's education support team for the parent component of the Inclusive Education Programme is made up of an occupational therapist and community workers. Together, these workers implement three sets of activities: the relationship component; the skills and knowledge development component, and the discussion component.

According to CC, parents are often not aware of the role they have in facilitating their children's school readiness. Therefore, the relationship component provides activities that emphasise the importance of a parent's role in their child's development. CC believes that these activities will enable parents to a) feel that they are important in their children's development and to b) feel encouraged to continue supporting their children. These are short-term outcomes.

CC believes that because parents are not aware of what their children are learning in school, parents lack the basic knowledge required to support their children. Additionally, some parents feel ill-equipped to communicate with teachers about their children's development. In order for parents to feel more confident in communicating with teachers about their children's development, and for parents to be better equipped to support their children's school readiness, the skills and knowledge component consists of activities which show parents what children may experience in a classroom setting. For example, parents learn to hold pencils correctly and use other tools that their children would use in a classroom setting. Additionally, parents see drawings and cut-outs which serve as examples of what would be expected of their children at school. Two sets of cut-outs and drawings are shown to parents, one done by a child who has reached the expected developmental milestone, and then another set done by a child who has not reached the developmental milestone. These activities are

designed to lead to the short-term outcome, namely, to provide parents with knowledge about what is expected during each phase at school, so that parents can better support their children once they are in school. This enables parents to feel more confident and able to communicate with teachers, this is CC's medium-term outcome for this programme component.

According to CC, parents lack the necessary skills and knowledge required to support their children's school readiness at home. Therefore, the discussion component of this programme consists of discussions and take-home resources, as well as providing suggestions for education games parents can play with children at home. This is intended to enable parents to gain knowledge and skills to be used to assist children as they prepare to enter school (these are short-term outcomes).

All three sets of activities (termed components in the programme theory diagram), with their related activities, are thought to bring about the long-term outcome of enabling parents to support their children in school. According to the programme staff, however, parents' attitudes mediate this desired long-term programme outcome.

The programme staff state that for parents to be to supportive of their children parents need skills and knowledge. More than this, however, they also need support in shifting their attitudes from being focusing on what their children cannot do, to focusing on what their children can do (by taking an ability-centred view). The rationale for this mediator is that, according to CC, while the programme can equip parents with knowledge and skills, ultimately, parents will feel more motivated to support their children when parents believe that their efforts will result in their children achieving school readiness. On the other hand, even if parents are equipped with knowledge and skills, but they do not believe in their children's abilities, parents will not feel motivated to put in the effort required to support their children.

Figure 9 depicts the programme theory of the parent component of the Inclusive Education Programme, it shows the needs the programme component attempts to address, as well as the activities and the short-, medium- and long-term outcomes of the programme component. Appendix J documents the first draft of the programme theory for this programme.

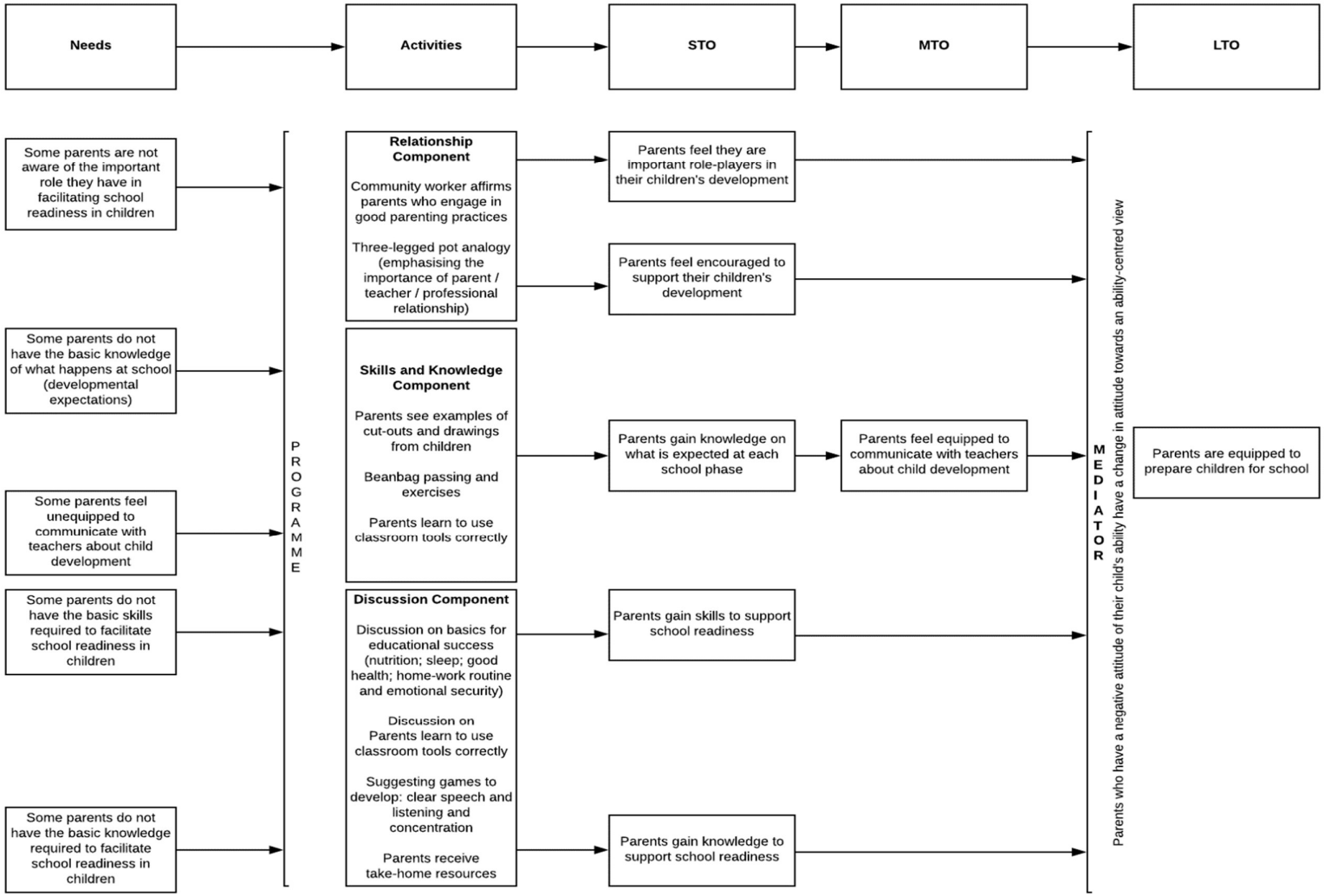

Figure 9. Programme theory for the parent component of the Inclusive Education Programme.

Plausibility of the parent component of the Inclusive Education Programme.

To assess the plausibility of CC's programme theory for the parent component of the Inclusive Education Programme, six comparable programmes were reviewed. Activities and outcomes reviewed in the literature, as well as CC's activities and outcomes were classified broadly.

Appendix J, Table J1 documents how activities were categorised. Of these six programmes, the most common broad activity was providing school and readiness information to parents. CC's programme theory includes this as an activity and CC's remaining activities were also found in one or more of the comparable programmes, as documented in Table 10.

Table 10

Broad Activities for CC's Parent Component of the Inclusive Education Programme and Comparable Programmes

Activity	Number of programmes (other than CC) including the activity	Reference to the publication	CC's inclusion of the activity
Affirming parents / feedback from implementers	3	Pears., et al., 2015; Sheridan et al., 2010; Whittingham, Sofronoff, Sheffield, & Sanders, 2009	Yes
Emphasising importance of parents' role / school / professional interaction	2	Sheridan et al., 2010	Yes
Modelling / roleplay	3	Ingersoll & Dvortcsak, 2006; Sheridan et al., 2010; Whittingham et al., 2009	No
Provision of parenting resources	2	Pears et al., 2015; Pelletier & Brent, 2002	Yes
School and readiness information / skills development by staff	5	Giallo, Treyvaud, Matthews, & Kienhuis, 2010; Ingersoll & Dvortcsak, 2006; Pears et al., 2015; Pelletier & Brent, 2002; Whittingham et al., 2009	Yes
Sharing development-related information by parents	2	Pears et al., 2015; Sheridan et al., 2010	No

Note. Total number of programmes reviewed = 6.

Note. The highlighted row indicates which outcome is the most common.

As seen in Table 10, CC's activities used in the parent component of the Inclusive Education Programme are aligned with activities used in comparable programmes. Due to CC aligning their activities with at least one other programme, their activities are plausible. However, it was also necessary to establish whether the intended outcomes included in CC's programme component were plausible.

Outcomes from the six programmes reviewed in the literature were classified into five categories. Appendix J (Table J2) provides details on these classifications. The most common outcome found in these programmes was an increase in parent engagement or involvement with their child's learning. CC's programme theory

includes similar intended outcomes in their programme theory. While most of CC's intended outcomes align with comparable programmes, CC has one intended outcome not seen in other programmes, namely, parents feeling emotionally supported, as seen in Table 11.

Table 11

Broad (Intended) Outcomes for CC's Parent Component of the Inclusive Education Programme and Comparable Programmes

(Intended) Outcome	Number of programmes (other than CC) including the outcome	Reference to the publication	CC's inclusion of the intended outcome
Gaining skills and knowledge	2	Ingersoll & Dvortcsak, 2006: Pelletier & Brent, 2002	Yes
Increased parent engagement / involvement with child's learning	4	Giallo et al., 2010; Pears et al., 2015; Pelletier & Brent, 2002; Sheridan et al., 2010	Yes
Improved parenting	2	Pears et al., 2015; Whittingham et al., 2009	No
Increased parental self-efficacy (capacity and ability) and confidence in terms of preparing children for school	2	Giallo et al., 2010; Pelletier & Brent, 2002	Yes
Parents feel emotionally supported	0		Yes

Note. Total number of programmes reviewed = 6.

Note. The highlighted row indicates which outcome is the most common.

As seen in Table 11, most of the outcomes included in CC's parent component of the Inclusive Education Programme are aligned with similar programmes and therefore plausible. The evaluator assessed the plausibility of CC's links between activities and outcomes. This is discussed below.

Three of CC's four causal linkages were aligned with comparable programmes in using similar activities to develop intended outcomes. These were: a) parents gaining skills and knowledge, b) increased parent engagement or involvement with a child's learning and c) increased parental self-efficacy. Due to the majority of causal

linkages being aligned with literature, the evaluator concluded that this programme theory is plausible. These results can be seen in Table 12.

Table 12

CC's Causal Linkages for the Parent Component of the Inclusive Education Programme Assessed Against Comparable Programmes

CC's intended outcomes	Activities used by comparable programmes to develop outcomes	Reference to publication
Gaining skills and knowledge	Provision of parenting resources	Pelletier & Brent, 2002
	School and readiness information / skills development by staff	Ingersoll & Dvortcsak, 2006
Increased parent engagement / involvement with child's learning	Affirming parents / feedback from implementers	Sheridan et al., 2010
	School and readiness information / skills development by staff	Giallo et al., 2010
	Affirming parents / feedback from implementers	Pears et al., 2015
Increased parental self-efficacy (capacity and ability) and confidence in terms of preparing children for school	School and readiness information provision / skills development by staff	Giallo et al., 2010
	Gaining skills and knowledge	Pelletier & Brent, 2002
	Provision of parenting resources	Pelletier & Brent, 2002
Parents feel supported	Not found in literature reviewed	

In summary, the parent component of the Inclusive Education Programme is based on CC's theory that parents will be equipped to support children for school if CC's programme staff:

a) emphasise the important role parents have in their children development,

b) equip parents with skills and knowledge to support their children, and

c) discuss factors which promote child development.

This is based on the assumption that parents are not equipped to support their children for school because they lack the confidence and knowledge, and that they are not aware of the role they play in facilitating school readiness and child development.

The activities CC uses in this programme component are consistent with the activities used by similar programmes. Similarly, the outcomes CC intends to achieve are comparable to other programmes and the causal links between activities and

outcomes are plausible. As such, the programme theory for the parent component of the Inclusive Education Programme is plausible.

The next sub-section of this chapter reports on the Vocation and Rehabilitation programme theory developed by the evaluator and CC's programme stakeholders.

Vocation and Rehabilitation Programme.

The primary activity of the Vocation and Rehabilitation Programme is to offer an ongoing craft workshop to young adults with disabilities. The programme implementers stated that this programme has six different components.

The first component, the changing-tasks component (termed the juggling balls component by CC's staff) consists of facilitators encouraging YAwD to switch between tasks. In having to stop one task, and start another, YAwD practice being versatile and more dynamic (these are short-term outcomes). This is intended to address a tendency towards passivity in YAwD. The second component is the transference component, where crafts are used as a medium for YAwD to practice learning a new skill, and then implementing that skill in a different way. For example, a participant may be able to use a craft-making tool in a certain context, but struggle to use the same tool in a different environment. This activity is intended to give opportunities to practice sharing tools, and using tools in different contexts, which is a short-term outcome.

The participation and inclusion component refer to the encouragement YAwD receive from facilitators and staff to include themselves in all activities, despite whether or not the YAwD think they will be able to complete an activity or not. Linked to this is the social component, where YAwD go on group outings. Both of these components are intended to lead to the short-term outcomes of YAwD experiencing increased meaningful interactions with peers and community members, as well as being more confident to communicate with peers and facilitators. These two components address the limited opportunities YAwD have for spontaneous interaction with peers, and the lack of confidence many YAwD experience in communicating with others.

The decision-making component refers to incorporating opportunities for YAwD to make decisions in the craft workshops. For example, YAwD are encouraged to choose between different pens or paints when making crafts. This is a response to YAwD not making decisions for themselves, as they are often over-dependent on caregivers to make their daily decisions. In having the opportunity to practice making small decisions, such as choosing between paints, YAwD eventually grow in

confidence (short-term outcome) and then start to initiate making decisions for themselves, which is a medium-term outcome.

Lastly, the vocational skills component involves craft-making. This addresses the lack of vocational opportunities for YAwD. In making crafts on a regular basis, YAwD are intended to reach the short-term outcome of strengthening their craft-making skills. Some YAwD then proceed to the intended long-term outcome of selling their crafts. Individual goals and abilities determine whether or not participants proceed to the long-term outcome.

Collectively, the outcomes associated with all of the components should lead to the intended long-term outcome of increased self-efficacy in YAwD. Once YAwD have self-efficacy, CC believes that YAwD will have increased capacity and willingness to be actively involved in society (intended impact). Given the varying abilities and goals of the programme participants, young adults with disabilities experience this in different ways. For example, some of the participants start using social media as a means to be involved in society and use it as a platform to showcase their crafts and connect to employment opportunities. For others, active involvement may mean that they participate in activities, and communicate with peers and community members outside of their home environment.

In addition to the core components and outcomes discussed, programme staff stated that the programme has unintended outcomes. For example, through observing how YAwD perform in the various components of the programme, the occupational therapist has the opportunity to identify YAwD who may be able to enter the mainstream workforce. These young adults then receive individual support and are guided to find and retain employment. Figure 10 depicts the programme theory for the Vocation and Rehabilitation Programme. Appendix K documents the first draft programme theory for this programme.

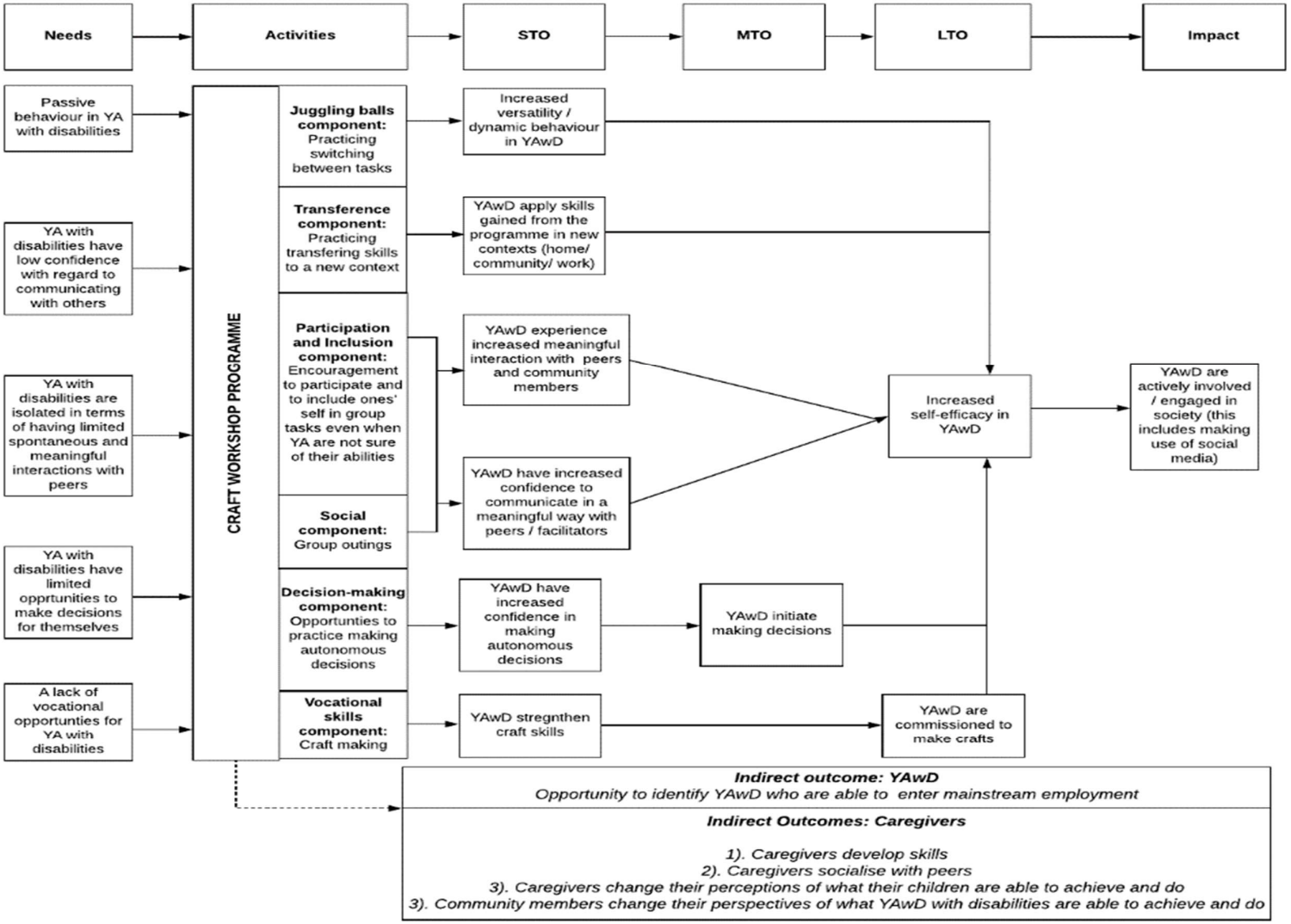

Figure 10. Programme theory for the Vocation and Rehabilitation Programme.

Plausibility of the Vocation and Rehabilitation Programme.

The evaluator assessed the plausibility of the programme theory depicted above in Figure 10, this included assessing the plausibility of the activities, intended, direct outcomes and impact. In assessing the plausibility of the Vocation and Rehabilitation Programme's activities, outcomes and causal linkages, nine comparable programmes were found.

The activities found in these nine programmes, were classified into ten broad activities. Appendix K (Table K1) details how these classifications were made. One broad activity was found to be the most common, namely, recreational activities and vocational skills development. CC uses this as an activity in their programme. All of CC's remaining activities were found in one or more of the comparable programmes reviewed as seen in Table 13.

Table 13

Broad Activities for CC's Vocation and Rehabilitation Programme and Comparable Programmes

Activity	Number of programmes (other than CC) including the activity	Reference to publication	CC's inclusion of the activity
Goal setting and monitoring	2	Palmer et al., 2012; Wehmeyer, Palmer, Agran, Mithaug, & Martin, 2000; Wehmeyer, Shogren,, Williams-Diehm, & Soukup, 2012;	No
Group sessions: education on jobs	2	Mueser et al., 2005; Tsang & Pearson, 2001; Watzke et al., 2009	No
Group sessions or individual sessions: problem solving	3	Palmer et al., 2012; Mueser et al, 2005; Wehmeyer et al., 2000	Yes
Group sessions: managing health	1	Mueser et al., 2005	No
Job coaching or facilitating entry into employment	4	Accordino & Herbert, 2000; Hillier et al., 2007; Mueser et al., 2005; Watzke et al., 2009	Yes
Occupational therapy group sessions: interpersonal skills development and social events	4	Accordino & Herbert, 2000; Mueser et al., 2005; Tsang & Pearson, 2001 Watzke et al., 2009	Yes
Recreational activities and vocational skills development	6	Accordino & Herbert, 2000; Hall, 2013; Hillier et al., 2007; Smit, de Brabander, & Martins, 2014; Watzke et al., 2009; Wehmeyer et al 2002	Yes
Self-regulation activities	2	Palmer et al., 2012; Wehmeyer et al., 2000	Yes
Sheltered employment	2	Accordino & Herbert, 2000; Watzke et al., 2009	No
Transferring skills to a new context	1	Tsang & Pearson, 2001	Yes

Note. Total number of programmes reviewed = 9.

Note. The highlighted row indicates which activity is the most common.

Given that the activities used in CC's Vocation and Rehabilitation are comparable to activities used by similar programmes, CC's activities for this programme are feasible.

The next step was to document the outcomes found in the nine comparable programmes. These were classified into ten broad outcomes. Table K2 in Appendix K documents how these classifications were made. Of these outcomes, the most common outcomes were a) being employed and b) achieving a sense of independence in decision-making (self-determination) or self-efficacy. CC included both of these outcomes in their programme theory. Results are documented in Table 14.

Table 14

Broad (Intended) Outcomes for CC's Vocation and Rehabilitation Programme and Comparable Programmes

(Intended) outcome	Number of programmes (other than CC) including the outcome	Reference to the publication	CC's inclusion of the outcome
Community participation / inclusion	1	Hall, 2013;	Yes
Employment	4	Accordino & Herbert, 2000; Hall, 2013; Hillier et al., 2007; Watzke et al., 2009	Yes
Goal attainment (individually set goals)	2	Palmer et al., 2012; Wehmeyer et al., 2000	Yes
Knowledge gain (employment related)	1	Mueser et al., 2005	No
Increased engagement in occupational domain other than work	2	Hall, 2013; Smit et al., 2014	Yes
Increased interpersonal skills	3	Hall, 2013; Smit et al., 2014; Tsang & Pearson, 2001	Yes
Increased versatility	1	Tsang & Pearson, 2001	Yes
Prevocational activity / skills development	1	Hall, 2013	Yes
Problem solving abilities increased	1	Wehmeyer et al., 2000	No
Sense of independence in decision-making / self-determination and self-efficacy	4	Hall, 2013, Palmer et al., 2012; Smit et al., 2014; Wehmeyer et al., 2000	Yes

Note. Total number of programmes reviewed = 9.

Note. The highlighted rows indicate which outcomes are the most common.

As seen in Table 14, CC's intended outcomes for the Vocation and Rehabilitation Programme are all outcomes found in similar programmes, as such, it is feasible to include these intended outcomes in CC's programme theory.

The final step in assessing plausibility was to identify causal linkages between activities and outcomes. The causal linkages in the Vocation and Rehabilitation Programme theory are aligned with similar programmes in developing the following intended broad outcomes: a) community participation / inclusion, b) employment, c) goal attainment, d) increased meaningful engagement in an occupational domain other than work, e) increased interpersonal skills, f) increased versatility, g) prevocational skills development and h) a sense of independence in decision-making (self-determination). Table 15 records the results.

Table 15

CC's Causal Links for the Vocation and Rehabilitation Programme Assessed Against Comparable Programmes

CC's intended outcome	Activities used by comparable programmes to develop outcome	Reference to publication
Community participation / inclusion	Recreational activities and vocational skills development (art, crafts and sport	Hall, 2013
Goal attainment	Goal setting and monitoring	Palmer et al., 2012; Wehmeyer et al., 2000
	Group sessions:	Palmer et al., 2012; Wehmeyer et al., 2000
	improved problem solving	
	Self-regulation activities	Palmer et al., 2012; Wehmeyer et al. 2000
	Recreational activities and vocational skills development (art, crafts and sport	Wehmeyer et al., 2000
Employment	Group sessions: improved problem solving	Mueser et al., 2005
	Job coaching or facilitating entry into employment	Accordino & Herbert, 2000; Hillier et al., 2007; Mueser et al., 2005; Watzke et al., 2009
	Occupational therapy group sessions: interpersonal skills development and social events	Accordino & Herbert, 2000; Watzke et al., 2009
	Recreational activities and vocational skills development (art, crafts and sport)	Accordino & Herbert, 2000; Hall, 2003; Hillier et al., 2007; Watzke et al., 2009
Increased interpersonal skills	Recreational activities and vocational skills development	Smit et al., 2014
	Group sessions: education on jobs	Tsang & Pearson, 2001
	Occupational therapy group sessions: interpersonal skills development and social events	Tsang & Pearson, 2001
	Transferring skills to a new context	Tsang & Pearson, 2001
Increased meaningful engagement in occupational domain other than work	Recreational activities and vocational skills development	Smit et al., 2014

Table 15 Continued

CC's Causal Links for the Vocation and Rehabilitation Programme Assessed Against Comparable Programmes

Increased Versatility	Group sessions: education on jobs	Tsang & Pearson, 2001
	Occupational therapy group sessions: interpersonal skills development and social events	Tsang & Pearson, 2001
	Transferring skills to a new context	Tsang & Pearson, 2001
Prevocational activity / skills development	Recreational activities and vocational skills development (art, crafts and sport)	Hall 2013
Sense of independence in decision-making / self-determination and self-efficacy	Recreational activities and vocational skills development	Hall, 2013; Smit et al., 2014; Wehmeyer et al., 2000
	Goal setting and monitoring	Palmer et al., 2012; Wehmeyer et al., 2000
	Group sessions: improved problem solving	Palmer et al., 2012; Wehmeyer et al., 2000
	Self-regulation activities	Palmer et al., 2012; Wehmeyer et al., 2000

Given that the causal linkages in CC's Vocation and Rehabilitation Programme are all aligned with those in comparable programmes, the programme theory for this programme is plausible.

In summary, the programme theory for the Vocation and Rehabilitation Programme is based on CC's belief that YAwD will have more self-efficacy and some may be commissioned to make crafts (both intended outcomes enable these individuals to be actively engaged in society) if the occupational therapist provides activities to:

a) increase versatility,

b) provide opportunities for practicing new skills,

c) provide opportunities for social engagement,

d) develop interpersonal skills and

e) strengthen craft skills.

This is because YAwD are assumed to be excluded from social and economic activities. The evaluator assessed the plausibility of activities and outcomes used by CC and the links between these activities and outcomes. These were all found to be plausible as comparable programmes had similar activities, outcomes and causal linkages.

The following section reports on the results for the MCDAs (Phase 2).

Results: Multi-Criteria Decision Analysis (Phase 2)

This section reports on the results of the three MCDA's conducted for CC. As a reminder to the reader, MCDAs were conducted for the two components of the Inclusive Education Programme and for the Vocation and Rehabilitation Programme. All MCDA's were used to respond to evaluation question two:

2) Who, according to CC's stakeholders is the most preferred implementer for the Vocation and Rehabilitation and Inclusive Education Programmes?

Results from each MCDA will be presented as they relate to the above evaluation question. Best practice guidelines require that evaluators report on a) stakeholders included in the analysis b) the decision problem, c) description of and rationale behind using criteria, d) sources of inconsistencies in judgements and e) comparison matrices (Marsh et al., 2016). Given that there are three MCDAs, there is limited space to present all the results. As such, some of the tables displaying results

can be found in the Appendices, a summary is provided in the dissertation and for further information the reader will be referred to the appropriate appendix and table number. Data providers for the MCDA's conducted were discussed in Chapter 3: Method (Table 4, page 49).

Inclusive Education Programme

Two MCDAs were conducted for the Inclusive Education Programme, one for the classroom component and the other for the parent component of the Inclusive Education Programme. The first step in an MCDA requires the evaluator to clearly define the problem the MCDA will attempt to address. Given that both the parent and the classroom components are part of the Inclusive Education Programme, the two components and their MCDAs address the same problem. A brief recap of the problem statement seen in Chapter 1 follows.

To implement both the parent and classroom components of the Inclusive Education Programme, CC makes use of two types of implementers, an occupational therapist and community workers. Together, they implement each session of the programme components. Because CC employs both, CC's programme costs are higher than if they only employed community workers. CC sees the input by occupational therapists as essential to the success of their programme, however funders are often reluctant to fund the additional cost of having an occupational therapist as a primary implementer. Given the difference of opinion between CC and programme donors, framed as the problem statement for this paper, the MCDA aims to consult programme stakeholders to elicit a rationale for why CC would need to use either a) an occupational therapist or b) community workers or c) both, for the Inclusive Education Programme to be successful.

For the purposes of this research, the two alternatives are defined as follows: an occupational therapist is a professional trained in disability and rehabilitation, while community workers are members of the communities in which they work. Community workers are usually trained in community development, their training could have included training in disability and rehabilitation. Both definitions are based on CC's use of and understandings of the two implementers.

For both MCDAs of the Inclusive Education Programme, the evaluator elicited criteria using various sources such as: programme goals, intended programme outcomes, literature, expert opinion as well as considering the practicalities or

maintenance factors of implementing these programme components. The criteria for each programme component differ, thus the criteria for each programme component will be discussed under the relevant sub-heading. This is followed by reporting on the results of the remaining steps for each programme component.

Classroom component of the Inclusive Education Programme.

The evaluator identified six programme criteria against which the alternatives would be judged: cost; qualification; designing programme activities; identification of disabilities; skills development of pre-schoolers and upskilling ECD practitioners (teachers) to be more inclusive in their classroom practices.

The first two criteria mentioned above were included in the analysis because they are deemed practicalities, or maintenance factors. Cost refers to the amount of money spent by CC in employing either an occupational therapist or a community worker. Qualification refers to whether an implementer's qualification is perceived as suitable for implementing the programme component. The remaining criteria were all derived from CC's programme objectives and intended outcomes. An implementer's ability to design programme activities was included in the analysis as designing new activities enables CC to keep up with the changing needs of teachers and children. An implementer's ability to identify children with disabilities ensures that CC's intended outcome of identifying disabilities is considered when deciding on an implementer. An implementer's ability to strengthen pre-schoolers skills (skills development criterion) was derived from numerous intended outcomes, to ensure that child beneficiaries are being serviced appropriately. The criterion of upskilling teachers to be more inclusive in classroom practices ensures that the chosen implementer is able to implement the programme component in a way that benefits teachers.

The skills development criterion is further broken down into five sub-criteria, each reflecting an important skill required for pre-schoolers to achieve school readiness. Four of these sub-criteria were derived from the *South African National Curriculum Framework For Children From Birth to Four* (Department of Basic Education, 2015). There are: developing pre-schooler's communication skills; enabling pre-schoolers to express their creativity; promoting the general wellbeing of pre-schoolers and promoting a sense of identity and belonging in pre-schoolers. Including these sub-criteria aligns CC's programme component with national standards for early learning, thus assuring that the chosen implementer can achieve

national outcomes. The last sub-criterion under skills development is encouraging pre-schoolers to be more inclusive of people with disabilities. Figure 11 depicts this decision problem framework.

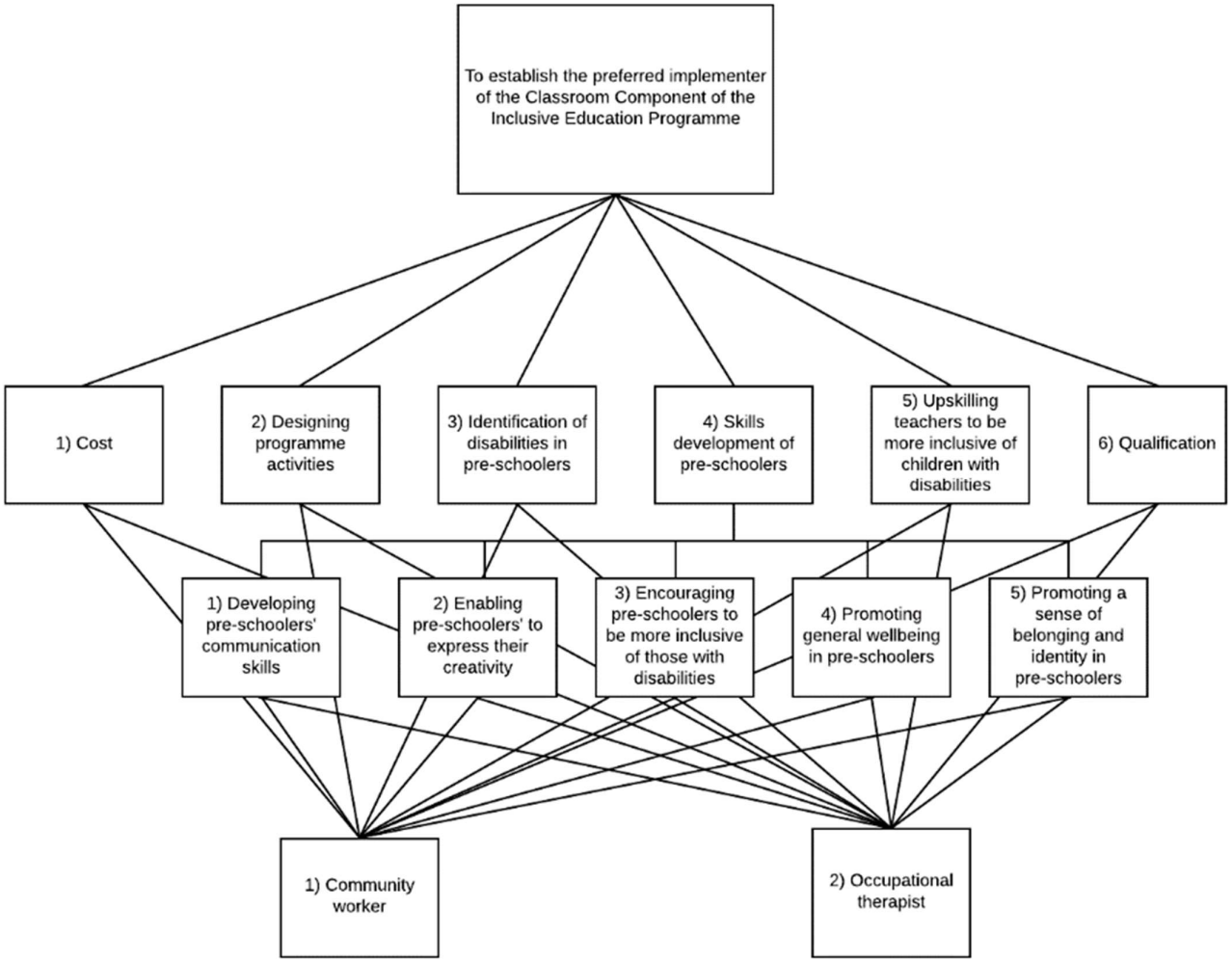

Figure 11. Decision problem framework for the classroom component of the Inclusive Education Programme.

The DMs first task in an MCDA is to rank the importance of the various programme criteria. Each DM selected which of the six criteria, and five sub-criteria were more important to them in considering the classroom component. Based on the responses, a Consistency Ratio (CR) was calculated for each DM. To remind the reader, the CR (discussed in chapter three, page 55) is a measure of a DM's consistency in their decisions. It should be equal to or less than 0,10, if it is higher than that, the evaluator must correct for inconsistent judgements by decreasing judgements to a suggested value of 2 (Mu & Pereyra-Rojas, 2017). All five DMs had CR ratios higher than 0,10, meaning that corrections were made as a result of their inconsistent judgements. Appendix L (Table L1) reports on these inconsistencies.

Once all DMs' CR ratios were at or below 0,10, the evaluator could aggregate individual judgements and run the analysis for all the DMs of the classroom component. This resulted in an acceptable CR of 0,0277.

Along with producing a CR value, running an analysis using the AHP technique results in two statistics being produced, the standardised and the idealised weight. The standardised statistic reflects the relative importance of or preference for a given criterion or alternative in relation to all the other criteria or alternatives (Mu & Pereyra-Rojas, 2017). As such, the standardised statistic can be read as a percentage indicating to what extent a criterion or alternative is preferred. The idealised statistic reflects which criterion or alternative is the best option, regardless of how well the other criteria or alternatives performed (Saaty, 2001). Thus, an ideal statistic of 1,0000 reflects that a criterion or alternative is the most preferred or important option.

Table 16 reflects these statistics as well as indicating the CR value for the analysis on weights of criteria, as perceived by all DMs of the classroom component. The comparison matrix used to derive the standardised and idealised weights can be found in Appendix L (Table L2).

Table 16

Weighted Programme Criteria for the Classroom Component of the Inclusive Education Programme

Criteria	Standardised Weight	Idealised Weight
Upskilling teachers to be more inclusive	0,2886	1,0000
Skills development of pre-schoolers	0,2658	0,9211
Designing programme activities	0,1848	0,6404
Identification of disabilities	0,1186	0,4111
Qualification	0,1041	0,3606
Cost	0,0381	0,1319

Note. CR = 0,0277.

As seen in Table 16 above, upskilling teachers to be more inclusive is ranked as the most important criterion with a standardised weight of 0,2886 and ideal weight of 1,0000. While cost is ranked as the least important, with a standardised weight of 0,0381 and ideal weight of 0,1319. The CR value for Table 16 is at an acceptable value of 0,0277 (below 0,10) indicating that the results are valid.

According to Table 16, the skills development of pre-schoolers is ranked as the second most important criterion with a standardised weight of 0,2658 and an idealised weight of 0,9211, indicating that this criterion is of relative significance to DMs. It is significant to note that the skills development of pre-schoolers criterion has its own set of sub-criteria. This meant that DMs had to weight the sub-criteria to establish which of these is the most important, this is discussed below.

Two DMs' individual judgements on sub-criteria were found to be inconsistent and are reported in Appendix L (Table L1). After having corrected the inconsistencies for these sub-criteria, the evaluator conducted the MCDA and ran an analysis to produce results on the weighting of sub-criteria as seen by all DMs. This resulted in an acceptable CR value of 0,0065, the evaluator aggregated the results and ran an analysis as well standardised and idealised weights of each sub-criterion, as seen in Table 17. The comparison matrix used to derive Table 17 can be found in Appendix L (Table L3).

Table 17

Weighted Sub-Criteria of Skills Development Criterion for the Classroom Component of the Inclusive Education Programme

Sub-criteria	Standardised Weight	Idealised Weight
Pre-schoolers' being more inclusive of children with disabilities	0,3011	1,0000
Pre-schoolers' communication skills	0,2420	0,8038
General well-being	0,1858	0,6171
A sense of identity and belonging in pre-schoolers	0,1749	0,5810
Creativity	0,0961	0,3190

Note. CR = 0,0065.

Based on the results presented in Table 17, DMs rank an implementer's ability to facilitate pre-schoolers being more inclusive of children with disabilities as the most important sub-criterion, with a standard weight of 0,3011 and an idealised weight of 1,0000. While creativity is ranked as the least important sub-criterion with a standard weight of 0,0961 and an ideal weight of 0,3190.

The next task for DMs is to indicate their preference for an implementer in relation to programme criteria and sub-criteria. Table 18 shows whether DMs prefer a community worker or occupational therapist to fulfil each criteria and sub-criteria. Table 18 also documents the CR values for the preferences. The comparison matrix for this task can be found in Appendix L (Table L4).

Table 18

Local Priorities for Alternatives for the Classroom Component of the Inclusive Education Programme

Criteria	Sub-criteria	Alternatives	Standardised local priority	Idealised local priority
Upskilling teachers to be more inclusive		Community worker	0,2727	0,7490
		Occupational therapist	0,7273	1,0000
Skills development of pre-schoolers	Pre-schoolers' being more inclusive of children with disabilities	Community worker	0,4202	0,7248
		Occupational therapist	0,5798	1,0000
	Pre-schoolers' communication skills	Community worker	0,5457	1,0000
		Occupational therapist	0,4543	0,8326
	General well-being	Community worker	0,4039	0,6776
		Occupational therapist	0,5961	1,0000
	A sense of identity and belonging	Community worker	0,7863	1,0000
		Occupational therapist	0,2137	0,2717
	Creativity	Community worker	0,4654	0,8706
		Occupational therapist	0,5346	1,0000
Designing programme activities		Community worker	0,1765	0,2144
		Occupational therapist	0,8235	1,0000
Identification of disabilities		Community worker	0,2276	0,2947
		Occupational therapist	0,7724	1,0000
Qualification		Community worker	0,4654	0,8706
		Occupational therapist	0,5346	1,0000
Cost		Community worker	0,3796	0,6118
		Occupational therapist	0,6204	1,0000

Note. CR = 0,0000 (perfect consistency).

As seen in Table 18, DMs preferred occupational therapists for eight of the programme criteria and sub-criteria. Community workers are preferred for two sub-criteria: a) developing a sense of identity and belonging in pre-schoolers and b) developing pre-schoolers' communication skills. It is important to note that the two sub-criteria for which community workers are preferred are both sub-criteria of skills

development of pre-schoolers, which the DMs see as the second most important criterion for the classroom component (noted in Table 16). Overall, these two criteria are ranked as the third and fifth most important criteria.

The next step for the programme evaluator was to synthesise the results. Synthesising takes both the weighting of criteria and sub-criteria as well as the preference scores for alternatives into account, resulting in an overall priority or preference score for the preferred implementer. The evaluator ran analyses to determine the differences between DMs, in terms of overall preference. Part of the confidentiality and consent agreement was that responses would be anonymous, so individual results are not presented in this evaluation. Presenting the results of DMs either individually or aggregated according to the stakeholder group would compromise individuals' anonymity, as the overall population is small, and a number of DMs know who provided the data. All DMs' responses were similar and are reflected in the aggregated overall results seen in Table 19.

Table 19

Synthesised Results (Overall Priority) for the Classroom Component of the Inclusive Education Programme

Alternative	Idealised overall priority	Standardised overall priority
Community worker	0,5114	0,3384
Occupational therapist	1,0000	0,6616

According to Table 19, gathered from DMs of the classroom component, an occupational therapist is the most preferred implementer for this programme with a standardised overall priority of 0,6616 (66,2 %) and an ideal score of 1,0000 (indicating the highest performing alternative). Community workers on the other hand, received a standardised overall priority of 0,3384 (33,8%) and an idealised overall priority of 0,5114.

To test the sensitivity of the judgements leading to these results, a sensitivity analysis was conducted. The evaluator opted to conduct a sensitivity analysis to establish how results would differ if all criteria and sub-criteria were weighted equally. Table 20 shows the results of the MCDA if all criteria were equally weighted, in other

words, Table 20 shows the results of the MCDA when none of the criteria are prioritised over the other criteria.

Table 20

Synthesised Results (Overall Priority) After Conducting Sensitivity Analysis for the Classroom Component of the Inclusive Education Programme

Alternatives	Idealised overall priority	Standardised overall priority
Community worker	0,5152	0,3400
Occupational therapist	1,0000	0,6600

As can be seen in Table 20, there are almost no changes in terms of which alternative is preferred, with an occupational therapist receiving a standardised global priority of 0,6600 and an ideal global priority of 1,0000, and community workers receiving a standard global priority of 0,34000 and an ideal global priority of 0,5152.

DMs were given an opportunity to provide, qualitative feedback on their responses to the MCDA. One overarching theme emerged from the qualitative feedback, DMs all stated that both community-workers and occupational therapists are needed to implement the programme, because each has unique competencies. As one respondent said:

> *"I think that there is a need for both a community worker and occupational therapist to run the programme together. They each have unique skill sets which complement each other."*
>
> (DM of the classroom component MCDA).[9]

In relation to the unique competencies each alternative is perceived to have, one DM stated that community workers perform a vital communication function required for accessing the beneficiaries. This is due to community workers generally being able to converse in the beneficiaries' mother-tongue, whereas the occupational therapist on this programme only speaks English.

> *"Community workers engage in mother tongue which is essential for access to the information and communication"*
>
> *(*DM of the classroom component MCDA).

[9] Due to confidentiality agreements, the DMs' reference numbers cannot be provided as this may compromise their anonymity.

The DM further stated that community workers would be able to implement a programme if the programme was already designed;

"*So, community workers would be able to run a programme if [it was] already set up."*

*(*DM of the classroom component MCDA).

In referring to the two alternatives' competencies, another DM makes reference to occupational therapists' ability to play a role in programme design and highlights that this is most important in cases where there are children with high-care needs;

[The] "OT (occupational therapist) is able to adapt and change activities and do on-site evaluations which improve the quality of the intervention - community worker unlikely to have these skills - this impacts the quality of the intervention and the effective outcome for children with more specialised needs."

*(*DM of the classroom component MCDA).

Similarly, a different DM refers to occupational therapists' competency in designing programme activities as well as referring to the issue of programme costs. This DM stated that while money for programme maintenance is an important consideration, occupational therapists' input is more important as they are required to design programmes in the first place. The following quote substantiates this,

"Without money the programme will not run so that is essential. Without OT[s] developing the programme and making changes to it as needed there would be no program to start with, irrespective of whether there's money to run the programme or not."

*(*DM of the classroom component MCDA).

It is important to note that this quote is the only quote that addresses the issue of programme costs.

In summary, the MCDA for the classroom component indicated that an occupational therapist is the most preferred implementer for the programme component as a whole. However, qualitative feedback from DMs indicate that there are particular roles for which community workers are essential, such as enabling CC to access communities, and communicating in mother-tongue languages with beneficiaries. Occupational therapists are required for designing programme activities and in cases where beneficiaries have high-care needs. Based on the MCDAs and the qualitative feedback outlined above, it can be concluded that both implementers are required for programme success.

Parent component of the Inclusive Education Programme.

In accordance with reporting practices for MCDAs the justification for DM selection was reported on in Chapter 3 Method (pages 48 - 49). The decision problem and the alternatives were identified on page 86 of this chapter.

The evaluator identified six criteria for the parent component. Three of which have been discussed, these being: cost, qualification and designing programme activities (page 86-87). The remaining criteria for this programme component are: educating parents on expected development of pre-schoolers (developmental education), preparing parents to support pre-schoolers readiness and supporting parents emotionally. Educating parents on the expected developmental outcomes for pre-school children was added to ensure that the chosen implementer can educate parents about children's development. Similarly, an implementer's ability to prepare parents to support their children's school readiness was added to aid in achieving the programmes intended long-term outcome. CC's programme theory also has an aspect of emotional support. Thus, the last criterion is an implementer's ability to provide emotional support to parents. These criteria, as well as the decision goal and alternatives are depicted in Figure 12.

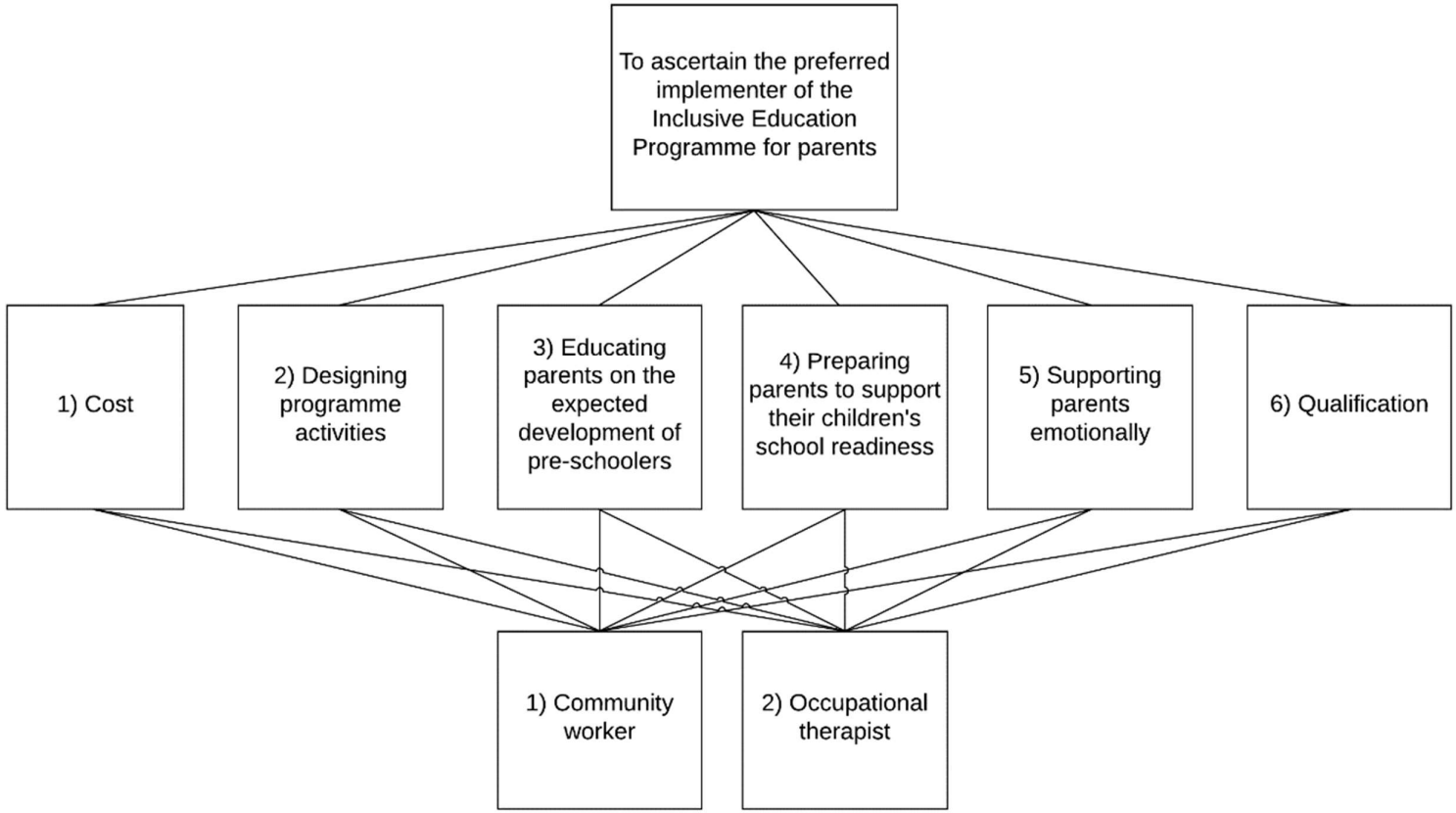

Figure 12. Decision problem framework for the parent component of the Inclusive Education Programme.

The first task for the DMs was to rank the programme criteria in order of importance. As with the classroom component, each DM was required to do this individually. This task yielded comparison matrices for each DM. As part of the comparison matrices, a CR value for each DM was calculated. Five of these values were deemed too high (above 0,10). The evaluator addressed the sources of inconsistencies for these DMs (a report detailing this process can be found in Appendix M (Table M1)). After these adjustments had been made, the evaluator ran the aggregated analysis. The resulting comparison matrix can be found in Appendix M (Table M2). Table 21 reports on the standardised and idealised weights assigned to each criterion as well as indicating an acceptable CR value of 0,0165. See Table 21.

Table 21

Weighted Programme Criteria for the Parent Component of the Inclusive Education Programme

Criteria	Standardised weight	Idealised weight
Developmental education	0,2523	1,0000
Designing programme activities	0,2153	0,8535
Supporting parents	0,2122	0,8412
Preparing parents to support readiness	0,2039	0,8083
Qualification	0,0608	0,2412
Cost	0,0554	0,2197

Note. CR = 0,0165.

As seen in Table 21, DMs perceive an implementer's ability to provide developmental education (educating parents on the expected development of pre-schoolers) as the most important criterion with a standardised weight of 0,2523 and an idealised weight of 1,0000. The criterion weighted as least important to DMs is cost, with a standardised weight of 0,0554 and an idealised weighting of 0,2197.

The next task for the DMs was to indicate their preferred alternative for each of the programme criteria. The aggregated comparison matrix can be found in Appendix

M (Table M3), and the standardised and idealised local priorities (preferences) for alternatives can be seen in Table 22.

Table 22

Local Priorities for Alternatives for the Parent Component of the Inclusive Education Programme

Criteria	Alternatives	Standardised priority	Idealised priority
Developmental education	Community Worker	0,6450	1,0000
	Occupational Therapist	0,3550	0,5503
Designing programme activities	Community Worker	0,1345	0,1554
	Occupational Therapist	0,8655	1,0000
Supporting parents	Community Worker	0,7887	1,0000
	Occupational Therapist	0,2113	0,2680
Preparing parents to support readiness	Community Worker	0,4895	0,9590
	Occupational Therapist	0,5105	1,0000
Qualification	Community Worker	0,2885	0,4055
	Occupational Therapist	0,7115	1,0000
Cost	Community Worker	0,5245	1,0000
	Occupational Therapist	0,4755	0,9067

Note. CR = 0,0000 (perfect consistency).

According to Table 22, DMs prefer community workers for three of the programme criteria and prefer occupational therapists for the remaining three. It is important to note that community workers are preferred when considering the most important criterion (according to DMs) namely developmental education, with a standard local priority of 0,6450 (65 %) and an ideal local priority of 1,0000. Occupational therapists are preferred for the second most important criterion, designing programme activities, with a standard local priority of 0,8655 (87 %) and an ideal local priority of 1,0000.

The evaluator synthesised the results presented in Tables 21 and 22, resulting in the final priorities for alternatives seen in Table 23. Bound by confidentiality agreements, the evaluator cannot report the exact differences in views between stakeholder groups. Table 23 shows the aggregated results, which mirrors the results of stakeholder groups, with small difference between scores.

Table 23

Synthesised Results (Overall Priority) for the Parent Component of the Inclusive Education Programme

Alternatives	Ideal overall priority	Standardised overall priority
Community Worker	1,0000	0,5055
Occupational Therapist	0,9782	0,4945

Community workers receive a standardised, overall priority of 0,5055 (50, 6 %) whereas occupational therapists received a standardised overall priority of 0,4945 (49, 5%). Idealised overall priorities for community workers and occupational therapists are 1,0000 and 0,9782 respectively.

To test for the sensitivity of the results seen in Table 23, the evaluator conducted a sensitivity analysis to see how results would differ if all criteria were weighted equally. Table 24 documents these results.

Table 24

Synthesised Results (Overall Priority) After Sensitivity Analysis for the Parent Component of the Inclusive Education Programme

Alternatives	Ideal overall priority	Standardised overall priority
Community Worker	0,9289	0,4816
Occupational Therapist	1,0000	0,5184

As seen in Table 24, the sensitivity analysis resulted in an occupational therapist being preferred instead of a community worker, as was the case before conducting the sensitivity analysis. According to Table 24, an occupational therapist is preferred with a standard overall priority of 0,5184 (51,8 %) and an ideal overall

priority of 1,000. Whereas a community worker receives a standard overall priority of 0,4816 (48,2 %) and an ideal overall priority of 0,9289.

Given that a) the MCDA's result, of preferring a community worker over an occupational therapist for the implementation of the Parent component, was marginal and therefore not sufficient to making a strong argument for using only community workers, and b) that the preferred alternative is inverted when criteria are weighted equally (indicating that these results could change if DMs decide to weight criteria differently), it can be argued that both implementers are required to implement the programme. The DMs weighted both very close to equally, the results here can be used to argue for both alternatives given the competencies each possess, as perceived by DMs.

The DMs who wished to give qualitative feedback on the MCDA were given the opportunity to do so. The feedback received in this section was very similar to the feedback received in the Classroom component: that both alternatives are required for effective implementation because of their different skill sets or competencies. Two of the four DMs who provided feedback stated that occupational therapists have more of the technical skills which are required to initiate the programme as well as to keep the programme relevant for beneficiaries, and that community workers function to connect beneficiaries with services. Quotes to substantiate this are provided.

The DMs of the MCDA provided qualitative feedback substantiating their responses. The overarching theme seen from this feedback is that both implementers are required for programme success given their unique competencies this is substantiated in the following quote:

"I believe programmes need both community workers and therapists"

(DM of the parent component MCDA).

Two DMs indicated that community workers are essential given their ability to access and communicate with communities, as well as their ability to support parents in the programme. Both also stated that occupational therapists are competent in technical skills required to design the programme and to keep the programme relevant, captured in the following quotes:

"Community worker brings value to support children and delivery of support to community whilst the occupational therapist brings technical standards and guidelines to the programme."

(DM of the parent component MCDA).

"OT is essential to this programme for design purposes and oversight and to drive the record keeping, adapt the programme to different groups to keep it relevant and dynamic and to mentor and grow capacity in community workers. Community workers are essential re emotional support and coming from within the community they already have established relationships with parents. Their ability to converse in mother tongue also creates an accessible to the material which is not possible for an OT who can possibly only speak English."

(DM of the parent component MCDA).

In considering the perceived competencies of both implementers, one DM proposed that an occupational therapist may only be necessary part-time, to adjust the programme activities when necessary and to provide supervision and additional information when required. This is substantiated in the following quote:

"Once the programme is up and running the therapist could pop in to either modify the programme or to share other experiences."

(DM of the parent component MCDA).

In summary, the MCDA results for the parent component of the Inclusive Education Programme indicate that CC's stakeholders prefer both implementers to implement the parent component of the Inclusive Education Programme. Similarly, the qualitative feedback indicates a need for both implementers on the programme, given the technical skills of an occupational therapist and community workers' ability to access and support beneficiaries. Further, qualitative feedback indicates the possibility of community workers implementing programmes while occupational therapists could provide part-time input.

Vocation and Rehabilitation Programme.

The last MCDA to be reported on was conducted for the Vocation and Rehabilitation Programme. As with the Inclusive Education Programme's MCDAs, the evaluator reports on the elements of the MCDA required by best practice guidelines.

The following reports on the decision problem of the MCDA as well as the alternatives. CC currently only employs one implementer on the Vocation and Rehabilitation Programme, an occupational therapist. In general, community workers are employed on other similar programmes. Employing community workers results in a significantly reduced staffing cost on these programmes (Ataguba et al., 2012; van Rooyen, 2007). Thus far, CC has not consulted programme stakeholders to elicit their

views on who should implement the programme, as such, CC has had difficulty in providing a rationale for why they need to use an occupational therapist to implement this programme. As stated in the first chapter's problem statement, this has resulted in CC struggling to motivate for funds to maintain the costs associated with employing an occupational therapist.

The problem statement highlights that while CC believes an occupational therapist is required for programme success, potential donors believe a cheaper less-qualified employee would be sufficient. As such, at least two alternatives need to be considered in addressing the decision problem, the first alternative is an occupational therapist. Given that CC's current personnel capacity in other programmes, a community worker was chosen to be the second alternative.

The next step for the evaluator was to construct criteria by which the alternatives would be judged. These criteria, like those of the Inclusive Education Programme components' MCDAs were elicited using programme objectives, intended outcomes, expert opinion, literature as well as by considering practicalities. The evaluator identified nine criteria for the Vocation and Rehabilitation Programme's MCDA. Three of the criteria used in the Inclusive Education Programme components' MCDAs remain the same for this MCDA: cost, qualification and designing programme activities. The reader is referred to the section on the Inclusive Education Programme (page 88) to review these criteria if required. The remaining criteria are discussed here.

In order to ensure that the chosen implementer can achieve the programme's objective of creating an accepting space for YAwD, an implementer's ability to foster such an environment was included as a criterion. Another programme objective is to promote active community participation, so the evaluator added an implementer's ability to facilitate social integration as a criterion. Some of CC's intended outcomes seen in their programme theory relate to YAwD being commissioned to make crafts as well as identifying YAwD who may be able to enter the workforce. As such, the evaluator included an implementer's ability to a) facilitate a YAwD's entry into the workforce and b) identify YAwD who may be able to enter the mainstream workforce as programme criteria. Another intended outcome is to teach YAwD useful skills such as crafting, communication and social skills, thus an implementer's ability to teach useful skills is another criterion. Lastly, CC's programme theory includes the

unintended outcome of upskilling and equipping facilitators. The last criterion is an implementer's ability to transfer knowledge and skills to facilitators.

Figure 13 depicts the decision problem framework for CC's Vocation and Rehabilitation Programme.

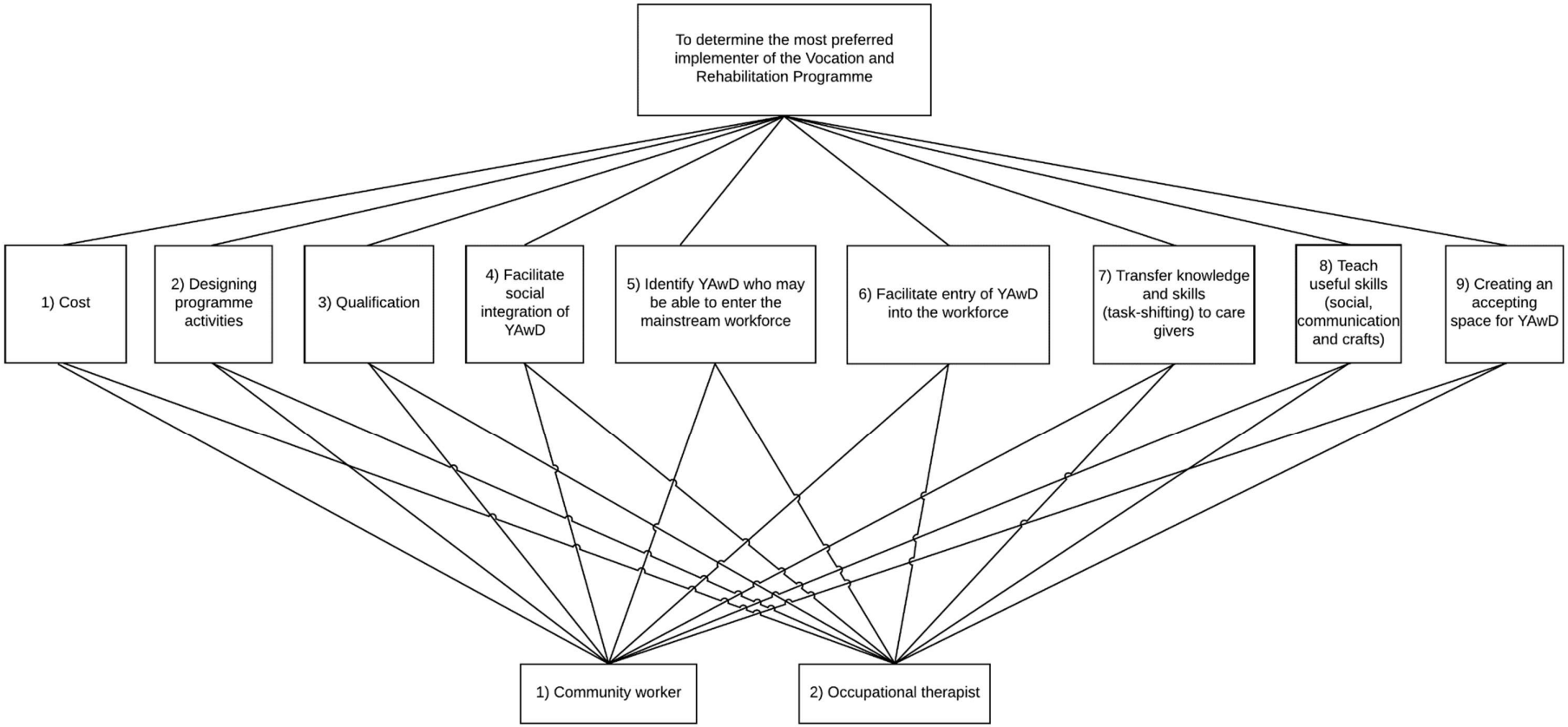

Figure 13. Decision problem framework for the Vocation and Rehabilitation Programme.

The DM's first task was to rate the importance, from their own perspectives, of the programme criteria. In doing this, CR values for each DM had to be calculated. Each DMs CR was above 0,10 and so the evaluator corrected for inconsistencies by adjusting judgements contributing to high CR values, to a recommended value of 2 (a detailed report on this is included in Appendix N (Table N1)). After having corrected for inconsistencies, the evaluator ran an aggregate analysis to establish criteria weights as perceived by DMs (the comparison matrix judgements can be seen in Appendix N (Table N2). This analysis resulted in an acceptable CR value of 0,0181 as well as standardised and idealised criteria weights, as seen in Table 25.

Table 25

Weighted Programme Criteria for the Vocation and Rehabilitation Programme

Criteria	Standardised weight	Idealised weight
Teaching useful skills to YAwD	0,2222	1,0000
Facilitating social integration of YAwD	0,1660	0,7471
Creating a safe environment for YAwD	0,1207	0,5432
Facilitating entry into workforce of YAwD	0,1063	0,4785
Skill to identify YAwD who may be able to enter the mainstream workforce	0,1029	0,4628
Designing activities	0,0974	0,4385
Transferring knowledge and skills to carers	0,0964	0,4337
Qualification	0,0630	0,2836
Cost	0,0250	0,1123

Note. CR = 0,0181.

As seen in Table 25, the DMs perceive the ability of an implementer to teach YAwD useful skills as the most important programme criterion, with a standardised weight of 0,2222 and an idealised weight of 1,0000. While the least important programme criterion is cost, with standardised and idealised weights of 0,0250 and 0,1123 respectively.

The second task for the DMs is to indicate their preference for an alternative in relation to the programme criterion. The comparison matrix for this task can be seen in Appendix N (Table N3). Table 26 shows the standardised and idealised local priorities for the preferred alternative for each of the programme criteria.

Table 26

Local Priorities for Alternatives for the Vocation and Rehabilitation Programme

Criteria	Alternatives	Standardised local priority	Idealised local priority
Teaching YAwD useful skills	Community worker	0,1934	0,2398
	Occupational therapist	0,8066	1,0000
Facilitating the social integration of YAwD	Community worker	0,4145	0,7079
	Occupational therapist	0,5855	1,0000
Creating an accepting environment for YAwD	Community worker	0,3562	0,5533
	Occupational therapist	0,6438	1,0000
Facilitating entry of YAwD into the workforce	Community worker	0,1322	0,1524
	Occupational therapist	0,8678	1,0000
Skill to identify YAwD who may be able to enter the mainstream workforce	Community worker	0,2658	0,3621
	Occupational therapist	0,7342	1,0000
Designing programme activities	Community worker	0,1233	0,1406
	Occupational therapist	0,8767	1,0000
Transferring knowledge and skills to carers	Community worker	0,2041	0,2565
	Occupational therapist	0,7959	1,0000
Qualification	Community worker	0,3562	0,5533
	Occupational therapist	0,6438	1,0000
Cost	Community worker	0,2038	0,2559
	Occupational therapist	0,7962	1,0000

Note. CR = 0,0000 (perfect consistency).

As seen in Table 26, DMs prefer occupational therapists for all of the programme criteria.

Having elicited the perceived importance of programme criteria, as well as the preferences for alternatives for the criteria, the evaluator could synthesise the results, seen in Table 27.

Table 27

Synthesised Results (Overall Priorities) for Alternatives for the Vocation and Rehabilitation Programme

Alternatives	Idealised overall priority	Standardised overall priority
Community worker	0,3431	0,2554
Occupational therapist	1,0000	0,7446

According to Table 27, an occupational therapist is strongly preferred with an ideal, overall priority of 1,0000 and a standard overall priority 0,7446 (74,5%). A community worker, on the other hand, received an ideal overall priority of 0,3431 and a standard overall priority of 0,2554. To conclude the MCDA for this programme, the programme evaluator conducted a sensitivity analysis to establish how results would differ if all criteria were weighted equally, the results of which can be seen in Table 28.

Table 28

Synthesised Results (Overall Priorities) After the Sensitivity Analysis for the Vocation and Rehabilitation Programme

Alternative	Idealised overall priority	Standardised overall priority
Community worker	0,3332	0,2500
Occupational therapist	1,0000	0,7500

As seen in Table 28, an occupational therapist is still preferred when all programme criteria are weighted equally with a standardised global priority of 0,7500 (75%) and an ideal overall priority of 1,0000.

DMs provided qualitative feedback which revealed that occupational therapists are seen as most preferred due to the relationship between competencies gained through training specific to occupational therapists and the desired programme outcomes. The perceived competencies of occupational therapists identified here are:

a) technical skills, b) their ability to assist in achieving intended employment outcomes and c) the oversight function they perform. These three competencies are (according to CC's stakeholders) attributed to occupational therapists' specific training. The quotes below link occupational therapists' technical skills and their ability to create the intended employment outcomes in YAwD:

> *"An occupational therapist has the knowledge of activities that stimulate the brain as well as developing fine and gross motor skills, social interaction which is vital as well as understanding their physical and mental limitations. This is vital in being able to identify where they could fit in in the work environment."*
>
> (DM of the Vocation and Rehabilitation Programme's MCDA)

The next quote relates to the link between an occupational therapists' technical expertise and their programme planning skills (oversight activities).

> *"I think an OT would be a better candidate since they would have a deeper medical understanding of the various disabilities due to their training. This in turn would assist in programme planning since they would have some fore knowledge of possible strengths and possible weaknesses of different disabilities."*
>
> (DM of the Vocation and Rehabilitation Programme's MCDA)

Only two DMs provided feedback regarding the possible inclusion of community workers. Both of these DMs believe that a community worker would only be able to implement a programme that has been designed by an occupational therapist, and only after having been trained by the therapist. The two quotes that follow articulate the view that community workers could, after training, implement an already existing programme.

"*An occupational therapist is best placed to design a programme and train community workers to screen, identify and support adults with ID [intellectual disability] to OT [occupational therapist] for further assessment and a programme suited to develop their skills further. The social and empowerment components [referring to the community-based rehabilitation guidelines (WHO, 2010)] of Inclusive development can be implemented by a community worker, but the complexity of Livelihoods component [referring to the community-based rehabilitation guidelines (WHO, 2010)] needs the knowledge and skills of an OT [occupational therapist] to have more sustained success in employment outcomes*."

(DM of the Vocation and Rehabilitation Programme's MCDA)

"The goal of an OT should be to design a sustainable program (teaching social integration and useful skills to families and young adults with disabilities) that can be taught to community workers to run within communities where the OT may not have regular access. The relationships and trust that the community worker has within their communities will have a more meaningful impact and carry over is more likely where regular and relevant support is perceived."

(DM of the Vocation and Rehabilitation Programme's MCDA)

In summary, the MCDA for the Vocation and Rehabilitation Programme indicates that overall, DMs prefer an occupational therapist to implement this programme. This result is maintained even when all programme criteria are weighted equally.

Although the MCDAs indicate a preference for an occupational therapist to run the programme, some DMs (in the qualitative feedback which is not traditionally considered part of the MCDA) spoke about the possibility of community workers implementing an already existing programme. They indicated that this would require an occupational therapist's mentorship and support.

This chapter has described the results, the next chapter provides a discussion of these results.

Chapter 5: Discussion

This chapter is divided into two sections, the first discusses Phase 1, the programme theory results, and the second section discusses Phase 2: the MCDAs.

Phase 1: Programme Theories

The first phase of this evaluation elicited programme theories for two programmes: the Inclusive Education Programme (consisting of two programmes components, the classroom component and the parent component) and the Vocation and Rehabilitation Programme. The chapter then discusses the MCDA results. This is done in five stages: the first provides an overview of the MCDAs, the second discusses the classroom component of the Inclusive Education Programme. The third discusses the parent component of the Inclusive Education Programme. The fourth discusses the Vocation and Rehabilitation Programme and the fifth discusses conclusions and recommendations. The chapter concludes with limitations and reflections.

The therapy-driven programmes had not undergone any type of evaluation prior to this dissertation. These programmes did not have articulated or documented programme theories before this evaluation. CC's director expressed that as an organisation, CC has struggled to articulate what these programmes aim to do and how their aim is achieved. This dissertation addressed to this need.

According to Funnell and Rogers (2011) programme theories can be assessed for plausibility against existing theories. After the programme theories had been elicited and made explicit, the evaluator assessed the plausibility of these theories by evaluating the alignment of activities and desired outcomes. This was done by considering the causal links between activities and outcomes in consultation with social science and programme evaluation literature.

The evaluator reviewed the literature to check if CC's programme theories were aligned with relevant social science theories. CC's programme theories were found to be plausible and viable. To emphasise the feasibility of the programme theories, this section discusses these programme theories as they relate to existing social science theories. Both components of the Inclusive Education Programme are discussed collectively, followed by a discussion on the Vocation and Rehabilitation Programme's programme theory.

Inclusive Education Programme.

CC's overall approach to delivering the Inclusive Education Programme is to service parents, teachers and pre-schoolers.

One service delivery model in particular aligns very closely with the approach used by CC's in their Inclusive Education Programme. This is the Partnering for Change Model (Missiuna et al., 2012). Partnering for Change Model is an approach used in programmes similar to those of CC's Inclusive Education Programme. This service delivery model emphasises the need to include educators, learners, parents and implementers such as therapists to better achieve inclusive education outcomes for learners (Missiuna et al., 2012).

Missiuna et al (2012) explain that while the child's development is the ultimate focus of a programme, equipping parents through knowledge translation and creating partnerships with therapists supports the everyday development of children. By teaching educators to use inclusive practices such as differentiated instruction[10], accommodation and universal design for learning[11], educators create an environment conducive to inclusive learning (Missiuna et al.,2012). Figure 14 depicts the Partnering for Change Model (Missiuna et al; 2012).

[10] Differentiated instruction refers to modifying teaching styles to accommodate learners with higher care needs (Missiuna et al., 2012).

[11] Universal Design for Learning refers to teaching, whenever possible, in a way that is accessible and suitable to all learners without having to adapt practices for learners with specialised needs (Department of Social Development, 2016).

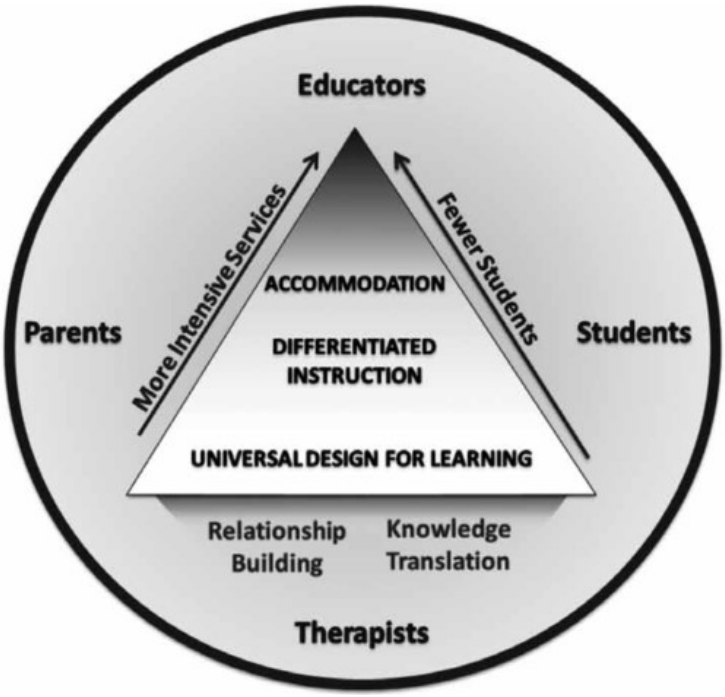

Figure 14. Partnering for Change Model by Missiuna, C. A., Pollock, N. A., Levac, D. E., Campbell, W. N., Whalen, S. D. S., Bennett, S. M., ... & Russell, D. J. (2012, p.43).

Chapter 1 discussed the context of inclusive education programmes. It was noted that as children's development is influenced by the home environment as well as the school environment, inclusive education programmes should aim to capacitate role players in both settings, such as parents and teachers. Considering this, CC's approach (of including parents, teachers and learners in their Inclusive Education Programme in order to facilitate school readiness and inclusive practices) is aligned with trends in the literature as well as the Education White Paper[12] on special needs and inclusive education (Department of Education, 2001; Hay, 2003; Missiuna et al., 2012; Pather, 2011; Struthers, 2005).

Vocation and Rehabilitation Programme.

CC's Vocation and Rehabilitation Programme shares similarities with Walker et al.'s (2011) writing on a social-ecological approach to self-determination for persons with disabilities. In their article, Walker et al (2011) define this approach as a social science model. CC's programme theory assumes that YAwD are excluded from social and economic activities because of their low self-efficacy. Similarly, Walker et al. (2011) discuss that many persons, particularly those with intellectual

[12] White Paper 6: Special Needs Education Building an Inclusive Education and Training System.

disabilities lack self-determination, which contributes to their social exclusion. Interventions should therefore aim to promote self-determination through facilitating opportunities to enable persons with disabilities to make choices for themselves and develop social capital (Walker et al., 2011). This equips persons with disabilities with the resources required for social integration (Walker et al., 2011). CC's Vocation and Rehabilitation Programme develops social capital and decision-making opportunities as they attempt to facilitate social integration.

Chapter 1 discussed the need for various activities in vocational rehabilitation programmes to address the varying livelihood needs of persons with disabilities. CC uses various activities to develop an array of intended outcomes on their Vocation and Rehabilitation Programme.

Based on this evaluation, it can be concluded that the two therapy-driven programmes implemented by CC are plausible and viable, and that they are aligned with international and national trends. The next section discusses the MCDAs conducted for CC's therapy-driven programmes.

Phase 2: Multi-Criteria Decision Analysis

This dissertation focused on two therapy-driven programmes implemented by CC. The Inclusive Education Programme has two components, the classroom component and the parent component. The overall objective of the classroom component is to create more inclusive ECD classrooms. The parent component aims to enable parents to better prepare their children for school. CC's Vocation and Rehabilitation Programme's overall objective is to teach YAwD useful skills to enable them to actively participate in society.

CC requires donor funding in order to implement these programmes. Both components of the Inclusive Education programme are currently facilitated and implemented by community development workers and occupational therapists. The Vocation and Rehabilitation programme is run by an occupational therapist, who receives support in facilitating the programme from volunteers. CC believes that community workers and occupational therapists are necessary implementers in order for the programmes to be successful.

The decision to use occupational therapists, however, is sometimes challenged by potential programme donors who are reluctant to fund the cost of an occupational therapists' ongoing input to the programmes. This is because occupational therapists

are significantly costlier than community workers. Other NPO's who implement similar programmes have reduced programme costs because they predominantly use community workers (Z. Grobler Mycroft, personal communication, 27th February 2017). This difference in cost resulted in the need to consider the cost / benefit of community workers or occupational therapists.

To address the cost / benefit question MCDAs were conducted for both components of the Inclusive Education Programme and for the Vocational and Rehabilitation Programme. The MCDAs aimed to elicit: a) which programme criterion was deemed to be the most important; b) whether a community worker or an occupational therapist are better suited to implement the programmes; and c) overall, taking into account the weightings and rankings of the programme criteria and the rating of the implementers, whether community workers or occupational therapists are the preferred implementers for the two programmes.

Inclusive Education Programme.

The discussion for the Inclusive Education Programme is presented in two parts, first the results for the classroom component are discussed, followed by the results for the parent component.

Classroom component of the Inclusive Education Programme.

Using the AHP approach to the MCDA CC's stakeholders weighted and ranked the following three programme criteria to be the most important:

1) Upskilling teachers to be more inclusive in their classroom practices,
2) Developing the skills of pre-schoolers, and
3) Designing programme activities.

All three of these criteria are rehabilitative. Each criterion is discussed below in relation to social science literature.

Top ranked criteria: Upskilling teachers to be more inclusive.

CC's stakeholders weighted the upskilling of teachers to be more inclusive in their classroom practices as the most important criterion. This is aligned with the national focus on upskilling teachers through education support teams. At the centre of the strategy outlined in the White Paper 6 (2001) is upskilling teachers (Dalton et al., 2012; Struthers, 2005; Yssel, Engelbrecht, Oswald, Eloff, & Swart, 2007). This is done in order for teachers to be better equipped to implement inclusive education to

learners with disabilities (Dalton et al., 2012; Struthers, 2005; Yssel et al., 2007 . CC's support teams aim to achieve this by a) developing good teaching strategies to include all learners, b) implementing strategies to overcome learning barriers, and c) using support systems in classrooms to achieve optimal inclusive education.

According to social science literature both community-based workers (such as community workers) and occupational therapists have successfully implemented inclusive education programmes and upskilled teachers (Lightfoot, 2004; Missiuna et al., 2012; Struthers, 2005). However, while community-based workers are competent in providing information on disability and inclusion to teachers, researchers argue that occupational therapists are better suited for this, given their training in inclusive education models (Dalton et al., 2012; de Jager, 2013; Missiuna et al., 2012; Pather, 2011; Struthers, 2005).

In the Western Cape, teachers have indicated that they need assistance in making the curriculum accessible to learners with specialised needs but that they are already overburdened (Struthers, 2005). The upskilling of these teachers requires an implementer to train and teach educators to support children with disabilities and varying needs (Barnes & Turner, 2001; Dalton et al., 2012). Struthers (2005) found that occupational therapists in the Western Cape have been effective in responding by providing onsite training on curriculum accessibility to teachers. Occupational therapists are able to train teachers to use the Universal Design for Learning (UDL) model. UDL is a technique to adjust teaching practices to make the curriculum accessible to all students (Dalton et al., 2012). Occupational therapists also upskill teachers by informing them about various instructional methods. Teachers are better able to support learners with specialised needs in the classroom, so that all learners can be included in everyday classroom tasks (Missiuna et al., 2012).

By upskilling teachers, occupational therapists are engaging in task-shifting, a process whereby professionals transfer their professional skills (in this instance regarding inclusive education) to other personnel such as teachers (Dawad & Jobson, 2011). An advantage of task-shifting to teachers is that they can then effectively implement these activities without the need for permanent support from occupational therapists (Barron & Padarath, 2017; Dawad & Jobson, 2011).

Criteria ranked second: Skills development of pre-schoolers.

The goal of any inclusive education programme is to support children's school performance. CC's stakeholders weighted and ranked the skills development of pre-schoolers as the second most important criterion. South Africa's inclusive education strategies dictate how to best develop the skills of all learners. These strategies are based on the principle that pre-schoolers require continuous care (Donohue & Bornman, 2014; Missiuna et al., 2012). In order to provide continuous care, primary care givers of children need to be upskilled (de Jager, 2013; Department of Education, 2001; Missiuna et al., 2012). This means that the key role players who assist in children's development, such as community members, teachers, parents and siblings, need to be provided with training and support (Missiuna et al., 2012).

CC's stakeholders prefer occupational therapists for three of the five sub-criteria of skills development, namely, a) pre-schoolers being more inclusive of children with disabilities, b) promoting the general wellbeing of children with disabilities, c) promoting the creativity of children. Whereas CC's stakeholders prefer community workers for a) developing communication skills of pre-schoolers and b) developing a sense of identity and belonging in pre-schoolers. Social science literature makes specific reference to occupational therapists competencies in facilitating the skills development of pre-schoolers in classroom settings (Missiuna et al., 2012; Struthers, 2005).

Aligned with the social model of disability, South Africa's inclusive education strategy promotes the use of indirect support to develop children's school skills (Department of Education, 2001) Indirect support requires the programme implementer to have knowledge of curriculum design. This knowledge is required in order to modify the curriculum to enable learners with more specialised needs to fully benefit from the way in which the teacher presents the curriculum (Missiuna et al., 2012; Struthers, 2005). Although there is little research on the competencies of implementers' relating to indirect support in the Western Cape, Struthers (2005) indicates that occupational therapists are competent in this regard. This finding supports the research of Missiuna et al (2012) who make specific reference to occupational therapists' competencies in facilitating the skills development of pre-schoolers in classroom settings.

Criteria ranked third most important: Designing programme activities.

CC's stakeholders weighted and ranked an implementer's ability to design programme activities as the third most important programme consideration. Children with disabilities have diverse needs, which change as they reach developmental milestones. In order to make the curriculum more accessible, implementers providing educational support need to redesign programme activities and adjust the way in which the curriculum is taught (Struthers, 2005). According to social science literature, these competencies are associated with rehabilitation therapists because of their training in adapting programmes to suit the individual needs of persons with disabilities (Chappell & Lorenzo, 2012). Similarly, CC's stakeholders prefer an occupational therapist to implement this programme criterion.

In summary, the rehabilitative criteria discussed above are more aligned with occupational therapists' skills and competencies. Thus, although community workers can implement other inclusive education programmes, CC's specific rehabilitative criteria require specialised skills and competencies in order to be most effective. Given that CC's stakeholders weighted the rehabilitative criteria to be important, intuitively it makes sense that occupational therapists were chosen as the preferred implementer for CC's classroom component.

The results for the parent component of the Inclusive Education Programme are discussed below.

Parent component of the Inclusive Education Programme.

South Africa's policy and legislation acknowledges that in order for children to be included in schools, the parents of these children need to be capacitated to better facilitate the development of their children (de Jager, 2013; Yssel et al., 2007). Thus, education support teams should:

- Assist parents to set transitional goals (pre-school to primary school) for their children
- Help create supportive family relationships,
- Strengthen ties between parents and the school system and
- Provide information on disability and health (health promotion) to help parents make better decisions for their children's development.

  (Hay, 2003; Missiuna et al., 2012; Struthers, 2005; WHO, UNESCO, ILO, 2010).

Social science literature indicates that both community workers and occupational therapists have implemented these programmes, often working in multi-disciplinary teams (Iemmi et al., 2016; Lehmann, 2008; Missiuna et al., 2012; Struthers, 2005). CC's stakeholders weighted and ranked the following as the most important programme criteria:

1) The ability to provide developmental information of children to parents,
2) Designing programme activities, and
3) Supporting parents.

Top ranked criteria: Developmental information.

South African legislation and researchers argue that the provision of information on disability and child development is essential to better equip parents to facilitate their children's development (Department of Education, 2001; Hay, 2003; Prinsloo, 2006). Accordingly, CC's stakeholders weighted the provision of information and capacitating parents to be the most important programme criterion.

In the Western Cape, Struthers (2005) found that parents felt doctors had not sufficiently explained their children's disabilities and the implications of these disabilities to them. This resulted in these parents not being able to adequately facilitate the development of their children. To address this, support teams should provide this information to parents in community based settings (Department of Education, 2001; Struthers, 2005). Social science literature indicates that while both occupational therapists and community workers can provide parents with the necessary information, Struthers (2005) found that parents are appreciative of having occupational therapists provide this information to them. However, communication between parents and occupational therapists can be problematic because of a language barrier that exists between parents and most occupational therapists in South Africa (Hay, 2003; Struthers, 2005). Due to this language barrier, the role of providing information to parents in South Africa is vital. This role is typically fulfilled by community-based workers (Lorenzo, van Pletzen, & Booyens, 2015; Thomson, 2016) Aligned with social science literature, CC's stakeholders prefer a community worker to implement this criterion.

Criteria ranked second most important: Designing programme activities.

CC's stakeholders weighted and ranked an implementer's ability to design programme activities as the second most important programme criteria. Parents of children with disabilities have differing needs, each of which are informed by their children's various needs (Struthers, 2005). As such it makes sense that an implementer of this criterion would need to be able to adapt programme activities to suit needs as they arise. As discussed earlier, occupational therapists have this competency. Similarly, CC's stakeholders prefer an occupational therapist for this programme criterion.

Criteria ranked third most important: Supporting parents.

Emotional support and psychological wellbeing are critical aspects of CBR programmes and the provision of such support is mandated by the WHO (WHO, 2002). The provision of emotional support is seen as part of capacitating parents to better support their children's school readiness (Struthers, 2005). According to CC's stakeholders an implementer's ability to provide emotional support to parents is the third most important programme criteria.

Social science literature indicates that both occupational therapists and community workers can provide emotional support. However, community-based workers are often better positioned to support parents in community-based settings, as they are members of the communities that they serve (Chappell & Johannsmeier, 2009; Chappell & Lorenzo, 2012; van Pletzen, Booyens, & Lorenzo, 2014). Community-based workers have been found to be competent in effectively supporting persons with disabilities and their families, leading to positive programme outcomes (Chappell & Lorenzo, 2012; Lorenzo et al., 2015). Aligned with the literature, CC's stakeholders prefer a community worker to implement this criterion.

CC's stakeholders argue that because CC's community workers have pre-existing relationships with beneficiaries, these workers are able to provide emotional support in a way that most occupational therapists are not. Social science literature supports this. According to Chappell and Johannsmeier (2009) because community-based workers in South Africa are generally members of the communities they serve; thus, beneficiaries often see these workers as approachable, relatable and find comfort in their relationships with community-based workers. Similarly, Thomson

(2016) documents how community-based workers form supportive bonds with community members.

In summary, given the variety of the programme criteria discussed above, the implementer of a programme such as CC's parent component of the Inclusive Education Programme would need a variety of skills. For example, there is a need for skills to design programme activities and there is also a need for an implementer to be skilled in the psychosocial aspects of rehabilitation in terms of supporting parents emotionally. Therefore, it makes sense that CC's stakeholders had an equal preference for community workers and occupational therapists to implement the parent component of the Inclusive Education Programme.

Vocation and Rehabilitation Programme.

Chapter 1 briefly outlines South Africa's commitment to ensuring employment equity for persons with disabilities. Vocational rehabilitation programmes are used to ensure that the vision of employment equity is realised. Although activities in these programmes differ substantially, national and international social science literature indicate that occupational therapists usually implement these programmes effectively (Buys, 2015; Coetzee et al., 2011; Crowther, Marshal, Bond, & Huxley, 2010; Reagon, 2011).

CC's Vocation and Rehabilitation programme has nine criteria, of these the following were weighted and ranked as the most important criteria:

1) An implementer's ability to teach YAwD useful skills,
2) An implementer's ability to facilitate social integration and
3) Creating a safe environment for YAwD.

Each criterion will be discussed below.

Top ranked criteria: Skills development.

In order to achieve employment equity, there is a need to integrate persons with disabilities into the labour force. For many South Africans with disabilities, however, the legacy of apartheid and the medical model have excluded them from educational opportunities to adequately develop skills. Therefore, the skills development of persons with disabilities is the cornerstone of vocational rehabilitation, and a first step towards social integration (Engelbrecht et al., 2002; Gathiram, 2008).

To address this need for skills development, departments such as the Department of Labour and Department of Health have undertaken programmes to expand the skills development of people individuals with disabilities through vocational rehabilitation. These programmes have had mixed results. Programmes focusing on the skills development of people with disabilities focus on a) foundational skills acquired through educational efforts, b) core life skills focusing on knowledge, attitudes and personal attributes, c), technical or professional skills and d) business or self-employment skills (WHO et al., 2010).

In line with the international and national focus on skills development of people, CC's stakeholders ranked and weighted the development of skills as the most important programme criterion. According to social science literature, community-based workers can more easily identify people with disabilities who require skills development (Chappell & Lorenzo, 2012). The actual development of skills, however, requires technical skills such as those possessed by occupational therapists (Buys, 2015; Coetzee et al., 2011). As such, these programmes are for the most part implemented by occupational therapists (Buys, 2015; Coetzee et al., 2011; van Biljon, 2016). Occupational therapists assess disabled people's functionality and their ability to work, thereafter occupational therapists train persons with disabilities in areas requiring further development (Buys, 2015; Coetzee et al., 2011; van Biljon, 2016). Given that the literature indicates that occupational therapists are able to develop the skills of persons with disabilities, it makes sense that CC's stakeholders prefer occupational therapists to implement the skills development of beneficiaries in CC's Vocation and Rehabilitation Programme.

Second ranked criteria: Facilitating social integration of YAwD.

People with intellectual disabilities are often more excluded from society more than population groups, because of this community and social participation is considered an important goal for people with intellectual disabilities in South Africa and abroad (Department of Social Development, 2016; Finkenflügel & Rule, 2008; Verdonschot, de Witte, Reichrath, Buntinx, & Curfs, 2009). In South Africa, the White Paper on Persons with Disabilities (2015) emphasises a rights-based approach to ensure equal participation. Thus, integrating persons with intellectual disabilities into social activities is seen as an important first step (Cummins & Lau, 2003). In line with this, CC's stakeholders weighted and ranked an implementer's ability to facilitate social integration as the second most important programme criterion.

Social integration is a process, consisting of various steps and levels of integration, rather than an activity (King et al., 2005). For example, one way to achieve social integration is for disabled persons to transition into meaningful social roles such as friendships or intimate relationships; occupational roles such as employment or volunteering; and leisure tasks such as participating in arts and crafts (King et al., 2005). Professionals such as occupational therapists are trained to assist individuals transition into these roles (Buys, 2015; van Biljon, 2016). This assistance is provided through coaching individuals on how to act and react in social roles, occupational roles and leisure tasks (King et al., 2005).

CC's stakeholders prefer an occupational therapist for this programme criterion. According to social science literature, community-based workers have certain relevant competencies such as understanding and engaging with power structures, family roles and in identifying barriers to social participation and integration (Chappell & Johannsmeier, 2009; Chappell & Lorenzo, 2012; Finkenflügel & Rule, 2008). Individuals with disabilities also require technical inputs, which are more readily provided by occupational therapists. For example, individuals with disabilities require assessments to determine their strengths, limitations and interests, thereafter an implementer can design a personal plan to achieve employment and vocational goals (King et al., 2005). Social science literature indicates that community-based workers may not have the technical skills required to facilitate transitioning into new roles (Chappell & Johannsmeier, 2009; Chappell & Lorenzo, 2012; Finkenflügel & Rule, 2008). CC's preference for an occupational therapist aligns with the literature.

Third ranked criteria: Creating a safe environment for YAwD.

In CC's context, a safe environment refers to an environment where YAwD can practice social skills such as decision making without fear of judgement or harmful consequences. In so doing, CC believes that creating a safe environment for YAwD provides YAwD the opportunity to practice skills required to facilitate social participation and inclusion. Being in a safe and supportive environment promotes relationships between people. Therefore, the setting in which programmes aiming to combat social exclusion take place is important for achieving social outcomes (King et al., 2005; Wilson et al., 2017). Researchers state that in order to facilitate social integration, programmes should create safe environments where disabled people are accepted (Abbott &

McConkey, 2006; King et al., 2005). CC's stakeholders weighted an implementer's ability to foster a safe environment for YAwD as the third most important programme criterion.

In order for these safe spaces to exist, programmes implementers need to engage in the psychosocial aspects of rehabilitation, facilitate peer support, address personal attitudes and community attitudes (Abbott & McConkey, 2006; Chappell & Johannsmeier, 2009). Chappell and Johannsmeier (2009) speak about community-based workers being competent in delivering the psychosocial aspect of rehabilitation as well harnessing peer support to facilitate social participation of persons with disabilities.

Abbott and McConkey (2006) state that some of the major barriers to social inclusion people with disabilities face are their personal beliefs regarding their own abilities and community attitudes. Community-based workers have been found to be competent in changing community attitudes, but occupational therapists are required to change personal beliefs and capitalise on a person's individual strengths (Abbot & McConkey, 2006; Chappell & Johannsmeier, 2009). CC's stakeholders prefer an occupational therapist for this programme criterion.

In summary, aligned with the trend of having occupational therapists as the primary implementers of programmes of this nature, CC's stakeholders prefer occupational therapists to implement their Vocation and Rehabilitation programme. Notably, this is the only programme where CC's stakeholders preferred occupational therapists for every programme criterion. Some of CC's Vocation and Rehabilitation Programme's criteria are complex and require technical competencies, thus it makes sense that CC's stakeholders would prefer occupational for these tasks.

Implications of the MCDAs.

In considering both of CC's therapy-driven programmes, social science literature indicates that in some situations, occupational therapists are better suited to implement some aspects of the programmes, whereas to effectively implement other aspects, community-based workers are required. For example, programmes with more technical aspects such as designing programme activities require occupational therapists' technical skills. Whereas the provision of emotional support, for example, is generally associated with community workers given that they have pre-existing relationships with programme beneficiaries. The evaluator notes that overall CC's stakeholders' preferences are aligned with the social science literature.

Recommendations

Given CC's problem statement, the focus of this evaluation was the MCDAs. Therefore, the evaluator has focused on providing recommendations in relation to the MCDAs. Before stating these recommendations, the evaluator briefly addresses the programme theory evaluations.

Programme theory.

From the programme theory evaluation conducted here, the evaluator concluded that CC's programme theories for the classroom and the parent components of the Inclusive Education Programme and the Vocation and Rehabilitation Programme are aligned with those of comparable programmes. The programme theories elicited in this evaluation were found to be plausible. CC can therefore use their programme theories to articulate their intended programme outcomes to potential programme donors (Funnell & Rogers, 2011). In addition to this, CC can utilise the programme theories to assist in future monitoring efforts by collecting data on indicators for the intended programme outcomes (Rossi et el., 2004). Lastly, the organisation can also use the programme theories as a basis for future evaluations of their programmes (Rossi et el., 2004).

MCDAs.

The results indicate a mismatch between stakeholders' priorities, in that they perceive occupational therapists to be the most beneficial implementer, and a donors' unwillingness to fund the use of occupational therapists specifically. Despite the underlying emphasis on cost in the problem statement, in all three MCDAs, stakeholders weighted cost as the least important programme consideration. Instead the implementers' ability to achieve programme objectives was deemed fundamental. Generally speaking, stakeholders believe that benefits outweigh costs (Wirz & Thomas, 2002). From the results of this evaluation, the evaluator makes the following two recommendations, these are detailed and justified further down:

- A community worker could implement the majority of the therapy-driven programmes, but an occupational therapist is required for the more technical aspects of programme implementation (this is discussed below, under the sub-heading: Using the results of this evaluation to inform implementer selection)

- To aid effective programme implementation and to upskill community workers, CC's community workers may benefit from receiving on-going supervision by occupational therapists (this is discussed below under the sub-heading: Community workers need supervision).

Using the results of this evaluation to inform implementer selection.

CC's potential donors believe that a community worker can implement the therapy-driven programmes. This evaluation found while there are aspects of the programmes that can be implemented by community workers, occupational therapists are preferred for some programme aspects. In cases where occupational therapists are not available, task-shifting to community-based workers is possible, but ideally CBR programmes should employ both professional and community-based workers (WHO, 2002). Even if task-shifting occurs, there is still a need for occupational therapists' input on CC's therapy-driven programmes. This is because the skills and competencies required for some activities are not within the scope of work of community workers (Ataguba et al., 2012).

The tables in Chapter 4: Results (Tables 18, 22 and 26) can be used by CC to identify which activities require an occupational therapist and which can be performed by a community worker for the Inclusive Education Programme and Vocation and Rehabilitation Programme. To illustrate how this can be done, the evaluator provides an example from the parent component of the Inclusive Education Programme. Table 29 was presented in Chapter 4: Results, CC can use this to motivate why the organisation needs an occupational therapist to implement some of the technical aspects of the Inclusive Education Programme. See Table 29.

Table 29

Example Results Table to Inform CC's Personnel Selection for the Parent Component of the Inclusive Education Programme

Criteria	Alternatives	Standardised priority	Idealised priority
Developmental education	Community Worker	0,6450	1,0000
	Occupational Therapist	0,3550	0,5503
Designing programme activities	Community Worker	0,1345	0,1554
	Occupational Therapist	0,8655	1,0000
Supporting parents	Community Worker	0,7887	1,0000
	Occupational Therapist	0,2113	0,2680
Preparing parents to support readiness	Community Worker	0,4895	0,9590
	Occupational Therapist	0,5105	1,0000
Qualification	Community Worker	0,2885	0,4055
	Occupational Therapist	0,7115	1,0000
Cost	Community Worker	0,5245	1,0000
	Occupational Therapist	0,4755	0,9067

Note. CR = 0,0000.

As seen in Table 29 above, stakeholders prefer occupational therapists to design programme activities and prepare parents to support their children's school readiness. Occupational therapists are also preferred for their qualification in the context of the parent component of the Inclusive Education Programme. Therefore, an occupational therapist could implement these specific activities, and a community worker could implement the remaining components. Where necessary, the community worker could receive support and supervision from an occupational therapist. Additionally, therapists could occasionally do site visits to ensure that the programme is up to date, and design new programme activities as required.

Given that CC currently uses both an occupational therapist and a community worker to implement all activities in the Inclusive Education Programme, which results in high programme costs, this recommendation will address CC's problem statement by possibly aiding in reducing programme costs without compromising the quality of the programmes. In order to maintain quality of services, community workers who implement activities independently of occupational therapists need supervision, this is discussed next.

Community workers need mentoring and supervision.

Community workers in South Africa have varying levels of qualification and are not always trained in disability or rehabilitation (Ataguba et al., 2012; van Rooyen, 2007). Therefore, there is a need for these workers to be supervised by personnel such as occupational therapists (Binken, Miller, & Concha, 2009; van Rooyen, 2007).

This supervision and mentoring are essential for both effective programme implementation and to upskill community development workers (Barron & Padarath, 2017; Binken et al., 2009; Chappell & Johannsmeier, 2009). Community workers who are not supervised and mentored by trained professionals such as occupational therapists may have a limited role to play in CBR, as they may encounter clients who have needs requiring skills that are not within the scope of community workers' skills (Chappell & Johannsmeier, 2009). If community workers are supervised and mentored by occupational therapists, they can receive guidance and training and refer clients onwards if needed (Finkenflügel, 2004). An additional benefit of this supervision is that community workers are upskilled through the feedback and support they receive from supervisors (Barron & Padarath, 2017; Struthers, 2005). Community workers receiving supervision and guidance from occupational therapists has been found to aid in effective programme implementation (Barron & Padarath, 2017; Binken et al., 2009; Chappell & Johannsmeier, 2009).

In CC's context, community workers can receive occasional off-site supervision from the occupational therapists. As suggested by Chappell and Johannsmeier (2009) this suggestion may aid in ensuring efficacy of CC's therapy-driven programmes. Because CC's programmes address various beneficiaries who have changing needs, this recommendation will aid community workers to set up appropriate referrals when beneficiaries require more technically skilled workers such as occupational therapists while reducing programme costs.

Concluding Remarks

As a first step of the evaluation approach used in this dissertation, programme theories were developed for the Vocation and Rehabilitation Programme and for the classroom and parent components of the Inclusive Education Programmes. Programme theories are integral to Theory-Driven programme evaluation and these can be assessed by assessing whether the causal linkages between activities and outcomes are aligned with comparable programmes (Funnell & Rogers, 2011; Rossi et al., 2004). This evaluation found that CC's programme theories, as elicited in this evaluation, are plausible when assessed against comparable programmes. Therefore, CC can use their programme theories to better articulate their programmes to donors.

The main focus of this dissertation was the MCDAs conducted in response to CC's problem statement, namely that potential donors perceive occupational therapists to be expensive when compared to community workers. Researchers warn against seeing community workers as a cheap method for implementing specialised programmes (Ataguba et al., 2012; Thomson, 2016; van Rooyen, 2007; Walker & Jan, 2005). This is because community workers serve a specific purpose (van Rooyen, 2007). This purpose should inform the selection of personnel to implement programmes rather than simply considering the cost of employing a given worker (Ataguba et al., 2012). This evaluation mirrors literature in that the role of community workers is not synonymous with professionals' roles (van Rooyen, 2007).

This evaluation found that some of the intangible benefits of community workers in CC's context include accessing and building relationships with hard-to-reach communities and addressing the language barrier found between the occupational therapist and programme beneficiaries. Occupational therapists on the other hand are valued for their medical and technical training required to design programme activities, their ability to upskill teachers to be more inclusive in classroom practices and teaching YAwD useful skills to facilitate their ability to participate in society. Therefore, CC can argue for the use of both community workers and occupational therapists to implement the programmes.

The evaluator acknowledges several limitations of this evaluation. These will be discussed in the final subsection of this dissertation.

Limitations and Reflections

There are a number of limitations with the method (MCDA) which the evaluator was required to use. This section outlines the most pressing of those.

First, as was stated in Chapter 1: Introduction, the evaluator was required to use MCDA to address CC's cost-benefit problem. While the use of MCDAs in health care is common-place, the evaluator did not find any examples of the use of MCDA in the context of personnel selection in the field of interventions for persons with disabilities. There was, thus, little literature to guide the development of criteria. The evaluator however drew on available resources to guide the selection of these.

Second, as a result of conducting evaluations on two programmes, it was only possible to conduct the MCDAs with one hierarchy. In retrospect, it would have been better to conduct MCDAs using two hierarchies, one for cost and one for benefits of implementers. The cost hierarchy would be made up of programme costs associated with each implementer whereas the benefits would detail potential benefits such as an implementer's ability to upskill teachers or teach YAwD useful skills. This would have yielded useful data into which aspects of costs are weighted most importantly according to CC's stakeholders.

Third, it would have been beneficial to have the perspectives of YAwD as decision-makers in the MCDA for the Vocation and rehabilitation programme, however, the evaluator was not able to include YAwD in the data collection for this evaluation, for both ethical and logistical reasons. The absence of this data in the evaluation was unavoidable, though including it would have greatly improved the data generated. Similarly, it would have been beneficial to the field if this evaluation had included all workers typically associated with CBR as alternatives in the MCDAs. However, this evaluation was based on CC and given that CC does not currently have the resource capacity to consider employing additional workers(such as mid-level workers) it was not viable to include these alternatives in the evaluation.

The biggest limitation was that the evaluator was not able to include potential donors. According to CC, potential donors have stated that they are reluctant to fund the use of occupational therapists. Their inclusion as DMs would yield useful results given CC's problem statement. CC however requested that these stakeholders not be included in the evaluation as the organisation felt this may put further strain on their relationships with these donors. Given that these donors were not included, this evaluation can only make recommendations based on the opinions of the remaining stakeholders: current donors, beneficiaries, external field experts, CC's staff and facilitators.

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Appendices

Appendix A: A Brief History of the Disability Rights Movement in South Africa

Given that this research is located in the field of interventions for people with disabilities, this is a brief synopsis of the Disability Rights Movement and its influence on South Africa's national response to interventions for people with disabilities since the 1980's. The reason for focusing on this movement is that it significantly contributed to the South African government adopting a more comprehensive approach to delivering services for persons with disabilities which incorporates the use of not only professionals such as occupational therapists, but also community-based workers (Sherry, 2016). This comprehensive approach is highlighted given its influence on the type of interventions seen in South Africa today.

Traditionally, interventions for people with disabilities were implemented based on the medical model (Department of Social Development, 2016). The medical model, which is also known as the Individualistic or Bio-Medical Model (Mji et al., 2013), is based on a view in which people are seen as being having disabilities due to having some kind of health-related impairment. In other words, their impairment is the disability. Here the assumed best response to disability is medical intervention to treat or manage an impairment (WHO, 2002). Interventions before the 1980's, were based on rehabilitation implemented by professionals, such as therapists and doctors (Department of Social Development, 2016). This was generally provided on an individual basis and by limited welfare services (Department of Social Development, 2016). Similar to the economic and social injustices of this time, the quality and amount of disability care was provisioned based on race, and thus inaccessible for many (Howell, Chalken, & Alberts, 2006).

The Disability Rights Movement in South Africa, started by activists with disabilities and rehabilitation therapists in 1984, challenged the medical model of disability that was so prominent in South Africa at the time (Howell et al., 2006; Mji et al., 2013). According to these activists, the medical model failed to adequately meet the needs of persons with disabilities in terms of accessibility and relevant services, and the model was seen as placing the responsibility for change on the individual with the impairment, as opposed to the responsibility being a societal one (Mji et al., 2013; Rule et al., 2006).

A number of key groups operated under the umbrella of the Disability Rights Movement, each advocating for various rights of people with disabilities (Howell et el., 2006). Examples of key groups follow, firstly, The Self-Help Association of Paraplegics in Soweto (SHAP) advocated for the right of dignity as well as for interventions not to be delivered by professionals such as rehabilitation therapists and medical doctors (Howell et al., 2006). Secondly, Disabled People South Africa (DPSA) wanted people with disabilities to be seen as equal citizens (Howell, et al., 2006). This organisation promoted capacity-building initiatives in order to generate income, alleviate poverty, and break down boundaries which prohibited people with disabilities from accessing employment in the open labour market (Howell et al., 2006). In addition, DPSA called for legislation reform, such as for legislation and intervention responses to move away from the medical model of disability as well as aiming to raise public awareness of disability (Howell et al., 2006). Another group, the Rural Disability Action Group (RURACT), advocated for autonomy and self-employment through income generating projects, the aim of these groups was to promote opportunities to generate income given the high rate of economic and social exclusion amongst persons with disabilities (Rule et al., 2006).

By calling for reform away from the medical model, the movement advocated for professionals to move towards the social model of disability (Mji et al., 2013). The social model of disability views disability as a human rights issue, occurring when attitudinal and physical barriers in society causes people to have a disability (Mji et al., 2013). For example, assumptions that persons with disabilities cannot work in certain environments due to their impairments causes social and economic exclusion (Mji et al., 2013; Rule et al., 2006). In other words, the way the society responds to an individual's impairment causes them to have a disability (disadvantaged). The call here is for a political and social response to address the social barriers faced by people (WHO, 2002).

Generally speaking, the movements' significance is that its advocacy led to progressive legislative changes regarding disability where people with disabilities are seen as active citizens with equal rights, as opposed to sick citizens in need of help (Sherry, 2016). As a result of the combined efforts of the organisations in the Disability Rights Movement as well as the ANC government, the government's approach to disability was changed. The White Paper on an Integrated National Disability Strategy

(1997) is a prominent document outlining South Africa's then new approach to interventions (Department of Social Development, 2016).

The nation's change in approach to disability encompassed integrating aspects of the medical model while moving towards the social model of disability (Department of Social Development, 2016). For instance, initiatives shifted from being implemented by specialists in hospitals, to having an increase in services being implemented within beneficiaries' own communities by specialists and community-based workers (Department of Social Development, 2016). This approach embraces the strengths of two very different models, each of which reflects the multifaceted nature of how disability is experienced (Velema & Cornielje, 2016). South Africa's national approach is legislated through the White Paper on the Rights of Persons with Disabilities (No. 39792, 2016).

A key human rights instrument, The United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD) (2006), is intended to promote, protect, ensure and facilitate the:

> "…*full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities"* (UN, 2006; p. 4).

Because South Africa is a signatory, and has ratified the convention, interventions in South Africa are expected to adhere to the principles and concepts of the UNCRPD (UN, 2006). One way in which this is done is through implementing community-based rehabilitation.

Appendix B: Programme Theory Consent Forms

Dear Participant,

I am a postgraduate student at the University of Cape Town, studying Programme Evaluation. The Chaeli Campaign have approached me to assist in their endeavour to learn more about their therapy-driven programmes. As such I am conducting research on the Chaeli Campaign.

The first part of my research consists of documenting the rationale behind the programme activities and outcomes of the therapy-driven programmes. Because you are a stakeholder, I would like to include your opinion in my research. I invite you to participate in this research study by participating in a focus group at the Chaeli Campain.

If you consent to participating in this study, please sign the consent section of this letter. Participation is strictly voluntary, and you may withdraw at any time. The Commerce Faculty Ethics in Research Committee have approved this research.

The focus group will take approximately one hour of your time. There is no compensation for responding nor is there any known risk. I assure you that all the information obtained from the research will remain confidential. The focus group will be recorded for transcribing purposes but will not be used to identify any individual. Data collected will be stored under a password protected folder on Google drive, and will be reported as an aggregate group opinion.

Thank you for taking the time to assist me in my educational endeavour. The data collected will provide useful information to the Chaeli Campaign. If you require additional information or have any questions, please contact us on the e-mail addresses provided.

Sincerely,

Lara Minne

MNNLAR001@myuct.ac.za

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the course convener, Sarah Chapman (sarah.chapman@uct.ac.za).

By signing this consent form, I confirm that I am a willing participant for this research project and have had the opportunity to ask any questions.

| --- | --- | --- |
| Name of participant | Date | Signature |

| --- | --- | --- |
| Name of researcher | Date | Signature |

Appendix C1: Feedback Form for the First Draft Programme Theory: Classroom Component of the Inclusive Education Programme

First Draft Logic Model for the Classroom Component of the Inclusive Education Programme - Feedback Document

Dear Participant,

Thank you again for participating in the focus group. The purpose of this document is to collect feedback in order to edit the theory diagram constructed in the focus group. I will adjust the diagram in accordance with your feedback.

Feedback Questions:

1) Looking at ***need,*** are there any ***needs which your programme serves*** that should be added to the diagram?
2) Looking at the ***activities,*** are there any activities which need to be included?
3) Looking at the ***outcomes,*** are there any ***changes in participants*** not included?
4) Looking at the ***overall logic***, are there any changes you would recommend?

Appendix C2: Feedback Form for the First Draft Programme Theory: Parent Component of the Inclusive Education Programme

First Draft Logic Model for the Parent Component of the Inclusive Education Programme - Feedback Document

Dear Participant,

Thank you again for participating in the focus group. The purpose of this document is to collect feedback in order to edit the theory diagram constructed in the focus group. I will adjust the diagram in accordance with your feedback.

Feedback Questions:

1) Looking at ***need,*** are there any ***needs which your programme serves*** that should be added to the diagram?
2) Looking at the ***activities,*** are there any activities which need to be included?
3) Looking at the ***outcomes,*** are there any ***changes in participants*** not included?
4) Looking at the ***overall logic***, are there any changes you would recommend?

Appendix C3. Feedback Form for the First Draft Programme Theory: Vocation and Rehabilitation Programme

First Draft Logic Model for the Vocation and Rehabilitation Programme - Feedback Document

Dear Participant,

Thank you again for participating in the focus group. The purpose of this document is to collect feedback in order to edit the theory diagram constructed in the focus group. I will adjust the diagram in accordance with your feedback.

Feedback Questions:

1) Looking at ***need,*** are there any ***needs which your programme serves*** that should be added to the diagram?
2) Looking at the ***activities,*** are there any activities which need to be included?
3) Looking at the ***outcomes,*** are there any ***changes in participants*** not included?
4) Looking at the ***overall logic***, are there any changes you would recommend?

Appendix D: Plausibility Check for the Programme Theories – Literature Search Strategy

This section describes the methodology employed when gathering programme theories from social science literature.

The search strategy follows. Electronic databases were used to perform the searches, these included: Google Scholar; WorldCat; Wiley Online Library; PubMed; MEDLINE; Academic Search Premier, Science Direct and Sage. Additionally, electronic journals include: Disability and Rehabilitation; Disability, CBR and Inclusive Development, and, International Journal of Disability, Community & Rehabilitation. The search terms for each programme follows:

Classroom component of the Inclusive Education Programme.

The search consisted of the following primary search terms: *disability inclusive education programme*. The following terms were added to the primary search terms using the Boolean search strategy: AND classroom; AND *education support;* AND *program*; AND *intervention*; AND *evaluation*; AND *evaluating*; AND *clinical trial*; AND *evidence*; AND (*outcome* AND *evaluation)*; AND (*process* AND *evaluation)*; AND (*impact* AND *evaluation)*; AND (*efficacy* AND *evaluation)*; AND (*theory* AND *evaluation)*; AND *activities*; AND *causal mechanisms,* AND *logic.*

Parent component of the Inclusive Education Programme.

The primary search terms follow: *school readiness parenting programme.* Using the Boolean search strategy, the evaluator added the following terms: AND *guidelines*; AND *education support;* AND *program*; AND *intervention*; AND *evaluation*; AND *evaluating*; AND *clinical trial*; AND *evidence;* AND (*outcome* AND *evaluation)*; AND (*process* AND *evaluation)*; AND (*impact* AND *evaluation)*; AND (*efficacy* AND *evaluation)*; AND (*theory* AND *evaluation)*; AND *activities*; AND *causal mechanisms,* AND *logic.*

Vocation and Rehabilitation Programme.

The primary search terms follow: *vocational rehabilitation programme.* Using the Boolean search strategy, the evaluator added the following terms: AND *guidelines*; AND *training;* AND *program*; AND *intervention*; AND *evaluation*; AND *evaluating*; AND *clinical trial*; AND *evidence*; AND (*outcome* AND *evaluation)*; AND (*process* AND

evaluation); AND (*impact* AND *evaluation)*; AND (*efficacy* AND *evaluation)*; AND (*theory* AND *evaluation)*; AND *activities*; AND *causal mechanisms,* AND *logic.*

Appendix E: Overview of Software Used for MCDA

Qualtrics.

Qualtrics is a popular online platform used to create and disseminate questionnaires. The evaluator used a paid version of Qualtrics to create all questionnaires for Phase 2 of this research, as well as using Qualtrics to disseminate online questionnaires to those MCDA respondents who received the questionnaires online. Questionnaires were sent back to the evaluator via Qualtrics.

The reason for opting to use Qualtrics was that the evaluator was familiar with the software and the evaluator needed to use software that could disseminate questionnaires electronically. Qualtrics does not have an MCDA analysis function, thus the evaluator transferred data from the Qualtrics platform to Super Decisions v2 to analyse data.

Super Decisions v2.

Super Decisions v2, developed by Thomas Saaty (who also developed the AHP), is a decision-making software with a functionality to conduct MCDAs using the AHP (Saaty, 2001). The evaluator used a recent version of this software, Super Decisions v2, to create hierarchies and analyse MCDAs for Phase 2 of this research. There are two main reasons for using Super Decisions to construct hierarchies and analyse MCDAs using the AHP, namely, it is one of the only advanced software packages that is free and secondly, there are comprehensive manuals and user guides on conducting AHPs using Super Decisions (Dodgson et al., 2009; Mu & Pereyra-Rojas, 2017; Saaty, 2001).

Appendix F: MCDA Questionnaire (Classroom Component of the Inclusive Education Programme)

Inclusive Education Classroom Component Questionnaire

Dear Participant,

Given your participation with the Chaeli Campaign, I would like to ask you to please complete the following questionnaire.

The questionnaire is based on the ECD classroom sessions of the Inclusive Education Programme. These sessions aim to equip teachers to better include children with disabilities in all classroom activities, and to enable children to be more inclusive of those with disabilities. Your answers will help me to understand what parts of the Inclusive Education Programme (for children and teachers) you find most important, and if you think community workers or occupational therapists should run the programme.

The Commerce Faculty's Ethics in Research Committee have approved this research. Your participation is voluntary. You can stop the questionnaire at any time, even if you have started it. Your responses are anonymous. I will not be working with your specific answers, but with a summary of everyone's responses. The information you and others provide will only be used for this research.

The questionnaire will take approximately 25 minutes to complete.

If you would like any more information, please contact me via email: laraminne001@gmail.com or phone 073 833 0589.
Regards,

Lara Minne

Thank you for agreeing to participate in the questionnaire.

Your responses to this questionnaire should be based on **your own opinions, there are no right or wrong answers.** At the end of the questionnaire you can write any further thoughts you have about this research, for example if you would like to give reasons for your responses.

Before you begin, please choose the option that best fits your involvement with the programme

- ○ Teacher in the Inclusive Education Programme
- ○ Staff of the Inclusive Education Programme
- ○ Funder of the Inclusive Education Programme
- ○ Specialist in the disability field

How to answer the questions

For each question, you will be presented with two options at a time. You will be given a scale with numbers which you can use to indicate if you view the one option as being more important than the other **OR** whether you think they are equally important.

SECTION A

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to design programme activities?

The amount it costs for an implementer to run the programme									An implementer's ability to design programme activities								
Extremely more important	Very strongly more important		Strongly more important		Moderately more important			Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's skill to identify children with disabilities?

The amount it costs for an implementer to run the programme									An implementer's skill to identify children with disabilities								
Extremely more important	Very strongly more important		Strongly more important		Moderately more important			Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's qualification?

The amount it costs for an implementer to run the programme										An implementer's qualification							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to develop children's school skills?

The amount it costs for an implementer to run the programme										An implementer's ability to develop children's school skills							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to educate teachers how to work with children with disabilities?

The amount it costs for an implementer to run the programme										An implementer's ability to educate teachers on how to work with children with disabilities							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's skill to identify children with disabilities?

An implementer's ability to design programme activities										An implementer's skill to identify children with disabilities							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's qualification?

An implementer's ability to design programme activities										An implementer's qualification							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's skill to develop children's school skills?

An implementer's ability to design programme activities										An implementer's skill to develop children's school skills							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's ability to educate teachers how to include children with disabilities?

An implementer's ability to design programme activities										An implementer's ability to educate teachers on how to include children with disabilities							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's skill to identify children with disabilities **OR** 2) an implementer's qualification?

An implementer's skill to identify children with disabilities										**An implementer's qualification**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's skill to identify children with disabilities **OR** 2) an implementer's skill to develop children's school skills?

An implementer's skill to identify children with disabilities										**An implementer's skill to develop children's school skills**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's skill to identify children with disabilities **OR** 2) an implementer's ability to educate teachers how to include children with disabilities?

An implementer's skill to identify children with disabilities										**An implementer's ability to educate teachers on how to include children with disabilities**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's skill to develop children's school skills?

An implementer's qualification										**An implementer's skill to develop children's school skills**							
Extremely more important	Very strongly more important		Strongly more important		Moderately more important		Equally important			Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's ability to educate teachers how to include children with disabilities?

An implementer's qualification										**An implementer's ability to educate teachers on how to include children with disabilities**							
Extremely more important	Very strongly more important		Strongly more important		Moderately more important		Equally important			Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's skill to develop children's school skills **OR** 2) an implementer's ability to educate teachers how to include children with disabilities?

An implementer's skill to develop children's school skills									**An implementer's ability to educate teachers how to include children with disabilities**								
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) promoting pre-schoolers' sense of identity and belonging **OR** 2) promoting pre-schoolers' creativity?

Promoting pre-schoolers' sense identity and belonging									**Promoting pre-schoolers' creativity**								
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) promoting pre-schoolers' sense of identity and belonging **OR** 2) promoting pre-schoolers' general wellbeing?

Promoting pre-schoolers' sense identity and belonging									**Promoting pre-schoolers' general wellbeing**								
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) promoting pre-schoolers' sense of identity and belonging **OR** 2) encouraging pre-schoolers to be inclusive of children with disabilities?

Promoting pre-schoolers' sense of identity and belonging										**Encouraging pre-schoolers to be more inclusive of children with disabilities**								
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important		
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9		
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○		

Which of the following are more important: 1) promoting pre-schoolers' sense of identity and belonging **OR** 2) developing pre-schoolers' communication skills?

Promoting pre-schoolers' sense of identity and belonging										**Developing pre-schoolers' communication skills**								
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important		
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9		
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○		

Which of the following are more important: 1) promoting pre-schoolers' creativity **OR** 2) promoting pre-schoolers' general wellbeing?

Promoting pre-schoolers' creativity										**Promoting pre-schoolers' general wellbeing**								
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important		
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9		
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○		

Which of the following are more important: 1) promoting pre-schoolers' creativity **OR** 2) encouraging pre-schoolers to be more inclusive of children with disabilities?

Promoting pre-schoolers' creativity										**Encouraging pre-schoolers to be more inclusive of children with disabilities**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) promoting pre-schoolers' creativity **OR** 2) developing pre-schoolers' communication skills?

Promoting pre-schoolers' creativity										**Developing pre-schoolers' communication skills**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) promoting general wellbeing of pre-schoolers **OR** 2) encouraging pre-schoolers to be more inclusive of children with disabilities?

Promoting general wellbeing of pre-schoolers										**Encouraging pre-schoolers to be more inclusive of children with disabilities**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) promoting general wellbeing of pre-schoolers **OR** 2) developing pre-schoolers' communication skills?

Promoting general wellbeing of pre-schoolers										**Developing pre-schoolers' communication skills**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) encouraging pre-schoolers to be more inclusive of children with disabilities **OR** 2) developing pre-schoolers' communication skills?

Encouraging pre-schoolers to be more inclusive of children with disabilities										**Developing pre-schoolers' communication skills**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

SECTION B

This section is similar to Section A. For each question you will need to choose whether a community worker or occupational therapist is better suited as an implementer of the programme OR whether you think they are equally suited as implementers for the programme.

For the purposes of this research, the following definitions have been used for the two implementers:

Community Worker: Community workers come from the areas in which they work. They are usually trained in community development. Their training could have included training in disability and rehabilitation.

Occupational Therapist: A professional worker trained in disability and rehabilitation.

Which of the two implementers do you think is better suited to develop children's communication skills?

Community worker																Occupational therapist
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is better suited to develop children's identity and sense of belonging?

Community worker																Occupational therapist
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is better suited to teach children to be more inclusive of people with disabilities?

Community worker																Occupational therapist
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is better suited to develop children's wellbeing (emotional, physical and mental health of a child)?

Community worker																Occupational therapist
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is better suited to help children express their creativity?

Community worker																**Occupational therapist**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited when comparing their overall benefit to the programme with the cost for them to run the programme?

Community worker																**Occupational therapist**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is better suited to design programme activities?

Community worker																**Occupational therapist**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is better suited to identify children with disabilities?

Community worker																**Occupational therapist**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is better suited to run the programme?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is better suited to teach teachers inclusive practices?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

SECTION C

Feedback

This section of the questionnaire gives you an opportunity to provide additional feedback about which of the two implementers (community worker or occupational therapist) you prefer, and /or why you think a specific implementer is more suited to implement the Inclusive Education Programme for children and teachers. You are also able to provide any additional general feedback.

Please use the box below to type your feedback:

_____

_____

_____

_____

_____

Thank you for completing the questionnaire. Please click the next arrow to submit your response

Appendix G: MCDA Questionnaire (Parent Component of the Inclusive Education Programme)

Inclusive Education Parent Component Questionnaire

Dear Participant,

Given your participation with the Chaeli Campaign, I would like to ask you to please complete the following questionnaire.

The questionnaire is based on the Inclusive Education Programme for parents, which aims to empower and enable parents to better prepare their children for school readiness. Your answers will help me to understand what parts of the Inclusive Education Programme **(parent component)** you find most important, and if you think community workers or occupational therapists should run the programme.

The Commerce Faculty's Ethics in Research Committee have approved this research. Your participation is voluntary. You can stop the questionnaire at any time, even if you have started it. Your responses are anonymous. I will not be working with your specific answers, but with a summary of everyone's responses. The information you and others provide will only be used for this research.

The questionnaire will take approximately 25 minutes to complete.

If you would like any more information, please contact me via email: laraminne001@gmail.com or phone 073 833 0589.

Regards,

Lara Minne

Thank you for agreeing to participate in the questionnaire.

Your responses to this questionnaire should be based on **your own opinions, there are no right or wrong answers.** At the end of the questionnaire you can write any further thoughts you have about this research, for example if you would like to give reasons for your responses.

Before you begin, please choose the option that best fits your involvement with the programme

- ○ Parent in the Inclusive Education Programme
- ○ Staff of the Inclusive Education Programme
- ○ Funder / donor of the Inclusive Education Programme
- ○ Specialist in the disability field

How to answer the questions

For each question, you will be presented with two options at a time. You will be given a scale with numbers which you can use to indicate if you view the one option as being more important than the other **OR** whether you think they are equally important.

SECTION A

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's ability to prepare parents to support children's school readiness?

An implementer's qualification										**An implementer's ability to prepare parents to support children's school readiness**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's qualification **OR** 2) the amount it costs for an implementer to run the programme?

An implementer's qualification										**The amount it costs for an implementer to run the programme**							
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's ability to design programme activities?

An implementer's qualification										An implementer's ability to design programme activities							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's ability to educate parents about children's development?

An implementer's qualification										An implementer's ability to educate parents about children's development							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's ability to support parents emotionally?

An implementer's qualification										An implementer's ability to support parents emotionally							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○

Which of the following are more important: 1) an implementer's ability to prepare parents to support children's school readiness **OR** 2) the amount it costs for an implementer to run the programme?

An implementer's ability to prepare parents to support children's readiness										**The amount it costs for an implementer to run the programme**						
Extremely more important	Very strongly more important	Strongly more important	Moderately more important	Equally important	Moderately more important	Strongly more important	Very strongly more important	Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to prepare parents to support children's school readiness **OR** 2) an implementer's ability to design programme activities?

An implementer's ability to prepare parents to support children's readiness										**An implementer's ability to design programme activities**						
Extremely more important	Very strongly more important	Strongly more important	Moderately more important	Equally important	Moderately more important	Strongly more important	Very strongly more important	Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to prepare parents to support children's school readiness **OR** 2) an implementer's ability to educate parents about children's development?

An implementer's ability to prepare parents to support children's readiness										**An implementer's ability to educate parents about child development**						
Extremely more important	Very strongly more important	Strongly more important	Moderately more important	Equally important	Moderately more important	Strongly more important	Very strongly more important	Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to prepare parents to support children's school readiness **OR** 2) an implementer's ability to support parents emotionally?

An implementer's ability to prepare parents to support children's readiness										**An implementer's ability to support parents emotionally**						
Extremely more important	Very strongly more important	Strongly more important	Moderately more important	Equally important	Moderately more important	Strongly more important	Very strongly more important	Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to design programme activities?

The amount it costs for an implementer to to run the programme										**An implementer's ability to design programme activities**						
Extremely more important	Very strongly more important	Strongly more important	Moderately more important	Equally important	Moderately more important	Strongly more important	Very strongly more important	Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to educate parents about children's development?

The amount it costs for an implementer to run the programme																**An implementer's ability to educate parents about child development**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to support parents emotionally

The amount it costs for an implementer to run the programme																**An implementer's ability to support parents emotionally**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's ability to educate parents about children's development?

An implementer's ability to design programme activities																**An implementer's ability to education parents about child development**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's ability to support parents emotionally?

An implementer's ability to design programme activities												**An implementer's ability to support parents emotionally**				
Extremely more important	Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to educate parents about children's development **OR** 2) an implementer's ability to support parents emotionally?

An implementer's ability to educate parents about children's development												**An implementer's ability to support parents emotionally**				
Extremely more important	Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important	
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

SECTION B

This section is similar to Section A. For each question you will need to choose whether a community worker or occupational therapist is better suited as an implementer of the programme, OR whether you think they are equally suited as implementers of the programme.

For the purposes of this research, the following definitions have been used for the two implementers:

Community Worker: Community workers come from the areas in which they work. They are usually trained in community development. Their training could have included training in disability and rehabilitation.

Occupational Therapist: A professional worker trained in disability and rehabilitation.

Which of the two implementers is better suited to run the programme?

Community worker										**Occupational therapist**						
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is more suited to prepare parents to support children's school readiness?

Community worker										**Occupational therapist**						
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is more suited when comparing their overall benefit to the programme with the cost for them to run the programme?

Community worker										**Occupational therapist**						
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is better suited to design programme activities?

Community worker										**Occupational therapist**						
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is better suited to educate parents about children's development?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the two implementers do you think is better suited to emotionally support parents?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

SECTION C

Feedback

This section of the questionnaire gives you an opportunity to provide additional feedback about which of the two implementers (community worker or occupational therapist) you prefer, and /or why you think a specific implementer is more suitable to implement the Inclusive Education Programme for parents. You are also able to provide any additional general feedback.

Please use the box below to type your feedback:

_____

_____

_____

_____

_____

Thank you for completing the questionnaire. Please click the next arrow to submit your responses.

Appendix H: MCDA Questionnaire (Vocation and Rehabilitation Programme)

Vocation and Rehabilitation Programme Questionnaire

Dear Participant,

Given your participation with the Chaeli Campaign, I would like to ask you to please complete the following questionnaire.

The questionnaire is based on the Vocation and Rehabilitation Programme. Your answers will help me to understand what parts of the programme you find most important, and who you between an occupational therapist and community worker, you think should run the programme.

The Commerce Faculty's Ethics in Research Committee have approved this research. Your participation is voluntary. You can stop the questionnaire at any time, even if you have started it. Your responses are anonymous. I will not be working with your specific answers, but with a summary of everyone's responses. The information you and others provide will only be used for this research.

The questionnaire will take approximately 25 minutes to complete.

If you would like any more information, please contact me via email: laraminne001@gmail.com or phone 073 833 0589.

Regards,

Lara Minne

Thank you for agreeing to participate in the questionnaire.

Your responses to this questionnaire should be based on **your own opinions, there are no right or wrong answers.** At the end of the questionnaire you can write any further thoughts you have about this research, for example if you would like to give reasons for your responses.

Before you begin, please choose the option that best fits your involvement with the programme

- ○ Facilitator in the Vocation and Rehabilitation Programme
- ○ Staff of the Vocation and Rehabilitation Programme
- ○ Funder / Donor of the Vocation and Rehabilitation Programme
- ○ Specialist in the disability field

How to answer the questions

For each question, you will be presented with two options at a time. You will be given a scale with numbers which you can use to indicate if you view the one option as being more important than the other **OR** whether you think they are equally important.

SECTION A

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to create an accepting space for young adults with disabilities?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to design programme activities?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to facilitate young adults' (with disabilities) entry into the workforce?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to facilitate social integration of young adults with disabilities?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's qualification?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's skill to identify young adults with disabilities who may be able to enter the mainstream workforce?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementer's ability to transfer knowledge and skills to care givers?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) the amount it costs for an implementer to run the programme **OR** 2) an implementers' ability to teach young adults with disabilities useful skills (social, communication and crafts)?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to create an accepting space for young adults with disabilities **OR** 2) an implementer's ability to design programme activities?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to create an accepting space for young adults with disabilities **OR** 2) an implementer's ability to facilitate young adults' (with disabilities) entry into the workforce?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to create an accepting space for young adults with disabilities **OR** 2) an implementer's ability to facilitate social integration?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to create an accepting space for young adults with disabilities **OR** 2) an implementer's qualification?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to create an accepting space for young adults with disabilities **OR** 2) an implementer's skill to identify young adults with disabilities who may be able to enter the workforce?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to create an accepting space for young adults with disabilities **OR** 2) an implementer's ability to transfer knowledge and skills to caregivers?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to create an accepting space for young adults with disabilities **OR** 2) an implementer's ability to teach young adults with disabilities useful skills (social, communication and crafts)?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's ability to facilitate young adults' (with disabilities) entry into the workforce?

Option 1 **Option 2**

Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's ability to facilitate social integration?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's qualification?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's skill to identify young adults with disabilities who may be able to enter the workforce?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's ability to transfer knowledge and skills to caregivers?

Option 1										**Option 2**							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○

Which of the following are more important: 1) an implementer's ability to design programme activities **OR** 2) an implementer's ability to teach young adults with disabilities useful skills (social, communication and crafts)?

Option 1										**Option 2**							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○

Which of the following are more important: 1) an implementer's ability to facilitate young adults' (with disabilities) entry into the workforce **OR** 2) an implementer's ability to facilitate social integration?

Option 1										**Option 2**							
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	Moderately more important	3	4	Strongly more important	5	6	Very strongly more important	7	8	Extremely more important	9
○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○		○	○

Which of the following are more important: 1) an implementer's ability to facilitate young adults' (with disabilities) entry into the workforce **OR** 2) an implementer's qualification?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to facilitate young adults' (with disabilities) entry into the workforce **OR** 2) an implementer's skill to identify young adults with disabilities who may be able to enter the workforce?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to facilitate young adults' (with disabilities) entry into the workforce **OR** 2) an implementer's ability to transfer knowledge and skills to caregivers?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to facilitate young adults (with disabilities) entry into the workforce **OR** 2) an implementer's ability to teach young adults with disabilities useful skills (social, communication and crafts)?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to facilitate social integration **OR** 2) an implementer's qualification?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to facilitate social integration **OR** 2) an implementer's skill to identify young adults with disabilities who may be able to enter the workforce?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to facilitate social integration **OR** 2) an implementer's ability to transfer knowledge and skills to caregivers?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to facilitate social integration **OR** 2) an implementer's ability to teach young adults with disabilities useful skills (social, communication and crafts)?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's skill to identify young adults with disabilities who may be able to enter the workforce?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's ability to transfer knowledge and skills to caregivers?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's qualification **OR** 2) an implementer's ability to teach young adults with disabilities useful skills (social, communication and crafts)?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's skill to identify young adults with disabilities who may be able to enter the workforce **OR** 2) an implementer's ability to transfer knowledge and skills to caregivers?

Option 1																**Option 2**
Extremely more important	9	8	Very strongly more important	7	6	Strongly more important	5	4	Moderately more important	3	2	Equally important	1	2	3	4	Moderately more important	5	6	Strongly more important	7	8	Very strongly more important	9	Extremely more important
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's skill to identify young adults with disabilities who may be able to enter the workforce **OR** 2) an implementer's ability to teach young adults with disabilities useful skills (social, communication and crafts)?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which of the following are more important: 1) an implementer's ability to transfer knowledge and skills to care givers **OR** 2) an implementer's ability to teach young adults with disabilities useful skills (social, communication and crafts)?

Option 1																**Option 2**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

SECTION B

This section is similar to Section A. For each question you will need to choose whether a community worker or occupational therapist is better suited as an implementer of the programme OR whether you think they are equally suited as implementers for the programme.

For the purposes of this research, the following definitions have been used for the two implementers:

Community Worker: Community workers come from the areas in which they work. They are usually trained in community development. Their training could have included training in disability and rehabilitation.

Occupational Therapist: A professional worker trained in disability and rehabilitation.

Which implementer do you think is more suited when comparing their overall benefit to the programme with the amount it costs for them to run the programme?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited to provide an accepting space for young adults with disabilities?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited to design programme activities?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited to facilitate the entry of young adults with disabilities into the workforce?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited to facilitate social integration?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited to run the programme?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited to identify young adults (with disabilities) who may be able to enter the workforce?

Community worker																**Occupational therapist**
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited to transfer knowledge and skills to caregivers?

Community worker										**Occupational therapist**						
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Which implementer do you think is more suited to teach young adults with disabilities useful skills (social, communication and crafts)?

Community worker										**Occupational therapist**						
Extremely more important		Very strongly more important		Strongly more important		Moderately more important		Equally important		Moderately more important		Strongly more important		Very strongly more important		Extremely more important
9	8	7	6	5	4	3	2	1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

SECTION C

Feedback

This section of the questionnaire gives you an opportunity to provide additional feedback about which of the two implementers (community worker or occupational therapist) you prefer, and /or why you think a specific implementer is more suited to implement the Vocation and Rehabilitation Programme. You are also able to provide any additional general feedback.

Please use the box below to type your feedback:

_____

_____

_____

_____

_____

Thank you for completing the questionnaire. Please click the next arrow to submit your responses.

Appendix I: First Draft Programme Theory and Plausibility Check Classification Tables for the Classroom Component of the Inclusive Education Programme

Appendix I provides the first draft programme theory of CC's classroom component, as well as providing tables (Table I1 and Table I2) detailing how activities and outcomes were classified for this programme components plausibility check. Figure I below is the first draft programme theory for this programme component.

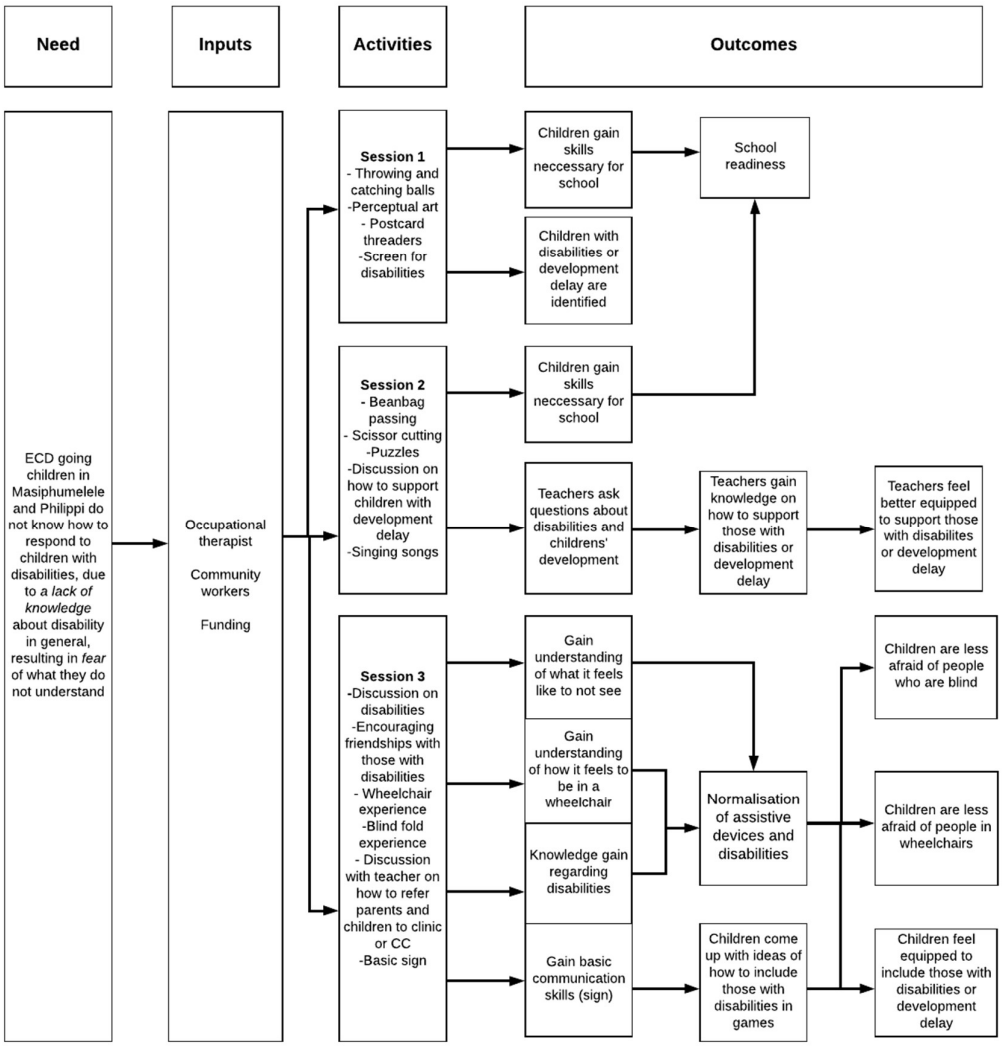

Figure I. First draft programme theory for the classroom component of the Inclusive Education Programme.

Table I1 below details how both CC's activities, as well as those used by other programmes were classified into broad activity groups to allow for easier cross-programme comparison.

Table I1
Activities Classification for the Classroom Component of the Inclusive Education Programme

Broad activity	CC's activity	Description of activity as seen in publication	Reference to publication
Activities teaching children how to use classroom tools	Set 1 part 1 (scissor cutting and puzzle building	Cutting, pasting, colouring	Rossi & Stuart, 2005
Arts music & story telling	Set 1 part 1 (perceptual art)	Stories and songs covering various themes such as bodies, families and animals	Rossi &Stuart, 2005
		Singing action songs	Sheppard et al., 2013
Basic numeracy games/activities	Not included in CC's programme theory	Counting	Rossi & Stuart, 2005
Disability-related talks and education	Set 2 (discussion on disability)	Discussion on disability	Cameron & Rutland, 2006
		Talk about what disability is	de Boer et al., 2014
		Educational stories on disability	Favazza et al., 2000
Friendship-promoting stories / discussion / activities	Set 2 (experiential learning and discussion on friendships)	Encouragement to play with differently-abled children (contact intervention)	Rossi & Stuart, 2005; Favazza et al., 2000
		Reading about how similar children without and with disabilities are	Cameron & Rutland, 2006
Gross-motor skills and co-ordination skills development	Set 1 part 1 (beanbag passing and postcard threading)	Moving	Rossi & Stuart, 2005
Information on development and health (aimed at teachers)	Set 3 (discussion on supporting children, Q & A and approaching parents)	Teachers are provided with child development information	Schepis et al., 2000
		Teachers are provided with information on disability and development	de Boer et al., 2014
Language-based activities / Early literacy	Not included in CC's programme theory	Learning letters, comprehension and writing	Pears et al., 2015; Rossi & Stuart, 2005
Screening for disabilities / developmental delay	Set 1 part 2 (screening for disabilities / developmental delay)		
Self-regulation activities	Not included in CC's programme theory	Learning to listen and wait	Sheppard et al., 2013

Table I2 below documents the classification details indicating how outcomes from CC and comparable programmes were categorised into broader outcome groups.

Table 12
Outcomes Classification for the Classroom Component of the Inclusive Education Programme

Broad outcome	CC's outcome	Description of outcome as seen in publication	Reference to publication
Change in attitude towards disabled children	Gaining empathy, reduced fear and normalisation of assistive devices	Viewing children with disabilities in a more positive light	Cameron & Rutland, 2006; Favazza et al., 2000
Children gain understanding and empathy	Children gain insight into what it feels like not to see and to use assistive devices		
Functional performance of school activities	Gaining skills necessary for school and school readiness	Improved eye-hand coordination enhanced cognitive performance	Rossi & Stuart, 2005
		Improved motor skills, ability to use classroom tools,	Sheppard et al., 2013
Gain knowledge regarding disabilities (children)	Children gain knowledge about disability		
Improved social skills	Children are equipped and inclusive of children with disabilities	Personal-social abilities improved	Rossi & Stuart, 2005
		Peer-play skills	Sheppard et al., 2013
Pre-schooler's language skills developed	Not included in CC's programme theory	Improved language	Sheppard et al., 2013
Self-regulatory Skills	Not included in CC's programme theory	Improved ability to sit and participate in classroom activities,	Sheppard et al., 2013
Upskilled teachers	Teachers are more inclusive in their classroom practices and teachers gain knowledge of disability	Improved teaching practices	Schepis et al., 2000

Appendix J: First Draft Programme Theory and Plausibility Check Classification Tables for the Parent Component of the Inclusive Education Programme

Appendix J provides the first draft programme theory of CC's parent component (Figure J page 203), as well as providing tables (Table J1, page 204 and Table J2 page 205) detailing how activities and outcomes were classified for this programme components plausibility check.

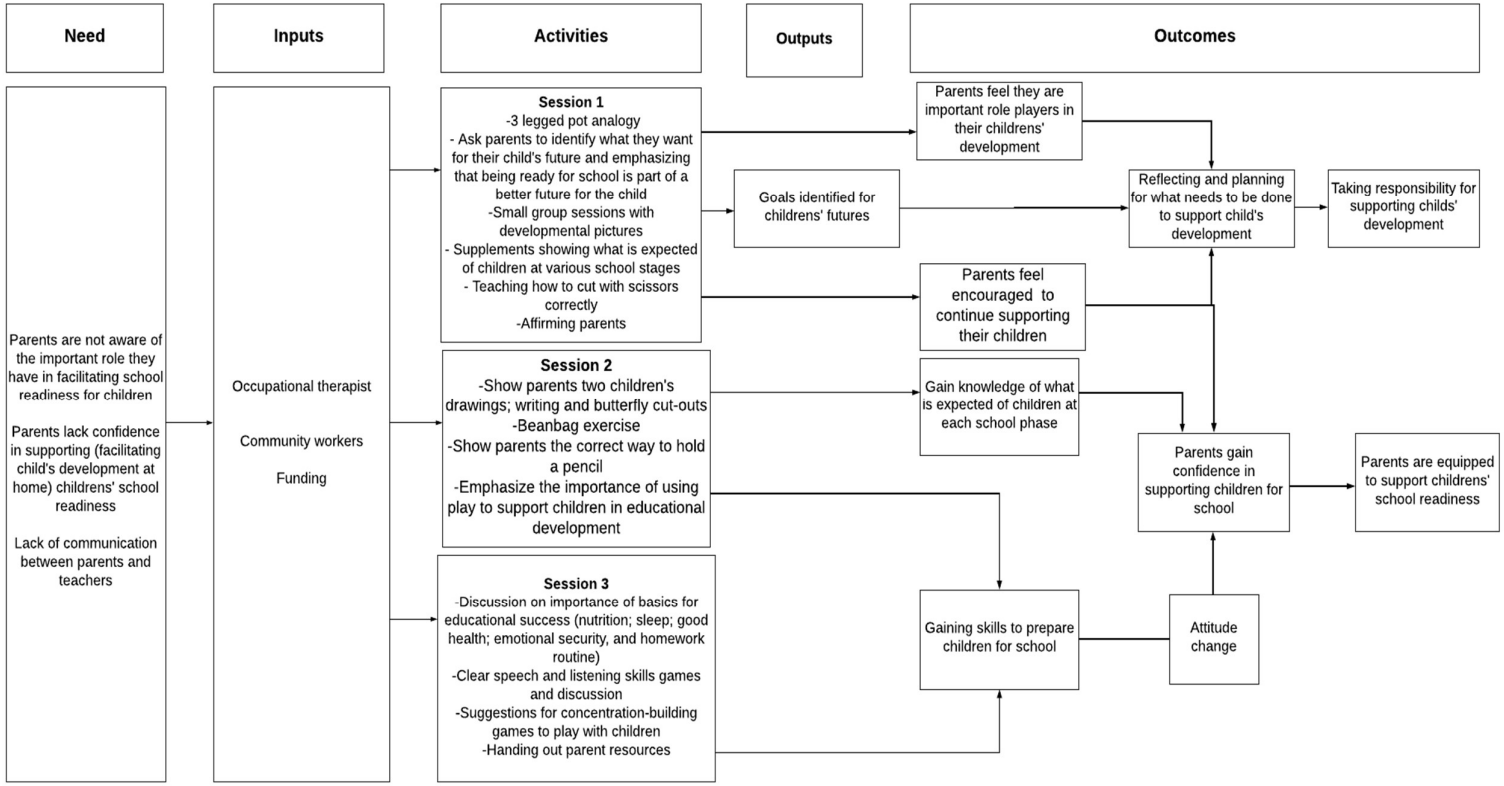

Figure J. First draft programme theory for the parent component of the Inclusive Education Programme.

Table J1

Activity Classification for the Parent Component of the Inclusive Education Programme

Broad activity	CC's activity	Description of activity in publication	Reference to publication
Affirming parents / feedback from implementers	Relationship component (affirming parents for good parenting practices)	Providing feedback on parenting strategies	Pears et al., 2015; Sheridan et al., 2010; Whittingham et al., 2009
Emphasising importance of parents' role / school / professional interaction	Relationship component (three-legged pot analogy)	Fostering parent / teacher relationships	Sheridan et al., 2010
Modelling / roleplay	Not included in CC's programme theory	Parent / child coaching Observe parent / child interaction and provide feedback on this	Ingersoll & Dvortcsak, 2006 Sheridan et al., 2010; Whittingham et al., 2009
Provision of parenting resources	Discussion component (take-home resources)	Parenting resources are provided to parents	Pears et al., 2015; Pelletier & Brent, 2002
School and readiness information / skills development by staff	Skills and knowledge component (parents see cut-outs and drawings; beanbag exercises and learning to use classroom tools	Parenting groups to provide school-related and child development information and skills to parents	Giallo et al., 2010; Pears et al., 2015; Pelletier & Brent, 2002; Whittingham et al., 2009
	Discussion component (basics for educational success and suggestions for games	Using videos to teach parenting practices	Ingersoll & Dvortcsak, 2006
Sharing development- related information by parents	Not included in CC's programme theory	Parents set and discuss goals related to development and parenting and discuss strategies to achieve these	Pears et al., 2015; Sheridan et al., 2010

Table J2

Outcomes Classification for the Parent Component of the Inclusive Education Programme

Broad outcome	CC's outcome	Description of outcome in publication	Reference to publication
Gaining skills and knowledge	Parents gain skills and knowledge related to supporting children for school readiness Parents learn about what is expected at each school phase	Increase in skills related to supporting child readiness	Ingersoll & Dvortcsak, 2006; Pelletier & Brent, 2002
Improved parenting		Positive parenting practices	Pears et al., 2015; Whittingham et al., 2009
Increased parent engagement / involvement with child's learning	Equipped to prepare children for school and communicate with teachers	"Parental warmth and sensitivity, support for a child's emerging autonomy, and active participation in learning" (p. 130)	Sheridan et al., 2010
		Increase in involvement with home-work and school activities	Giallo et al., 2010; Pears et al., 2015; Pelletier & Brent, 2002
Increased parental self-efficacy (capacity and ability) and confidence in terms of preparing children for school		Increase in self-efficacy	Giallo et al., 2010
Parents feel supported	Parents feel supported emotionally and feel that they are important in their children's development		

Appendix K: First Draft Programme Theory and Plausibility Check Classification Tables for the Vocation and Rehabilitation Programme

Appendix K provides the first draft programme theory of CC's Vocation and Rehabilitation Programme (Figure K page 207), as well as providing tables (Table K1, page 208 and Table K2 page 209) detailing how activities and outcomes were classified for this programme's plausibility check.

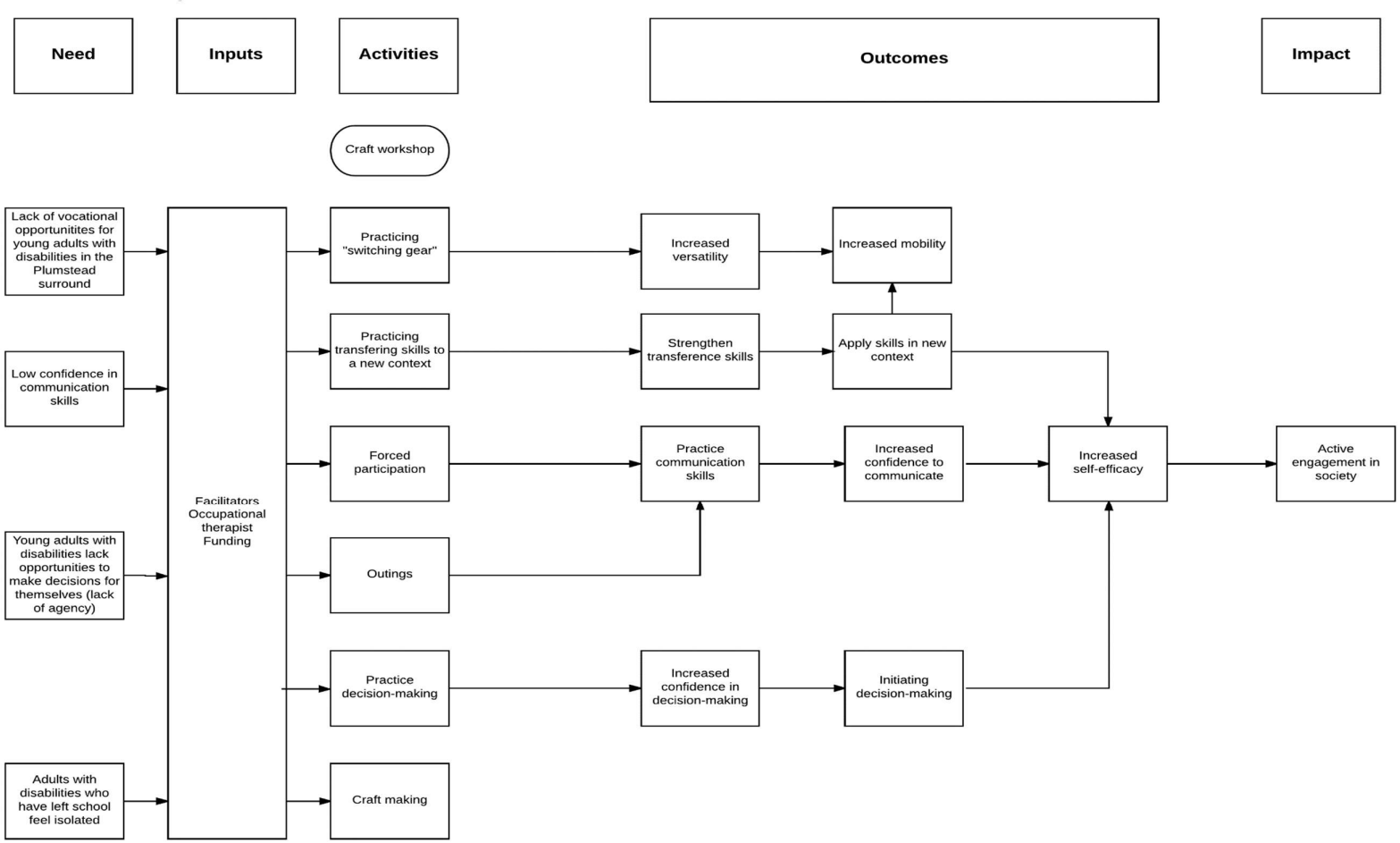

Figure K. First draft programme theory for the Vocation and Rehabilitation Programme.

Table K1
Activities Classification for the Vocation and Rehabilitation Programme

Broad activity	CC's activity	Description of activity in publication	Reference to publication
Goal setting and monitoring	Not included in CC's programme theory	Setting individual goals and monitoring progress	Palmer, 2012; Wehmeyer et al., 2000
Group sessions: education on jobs	Not included in CC's programme theory	Information on different aspects of retaining a job including: orientation to the working world and learning about the work environment and job performance	Mueser et al., 2005; Tsang & Pearson, 2001
		Unspecified further than providing education regarding jobs	Watzke et al., 2009
Group or individual sessions: Improved problem solving	Decision-making component	Skills training to better approach and solve problems	Mueser et al., 2005
		Self-directed questions related to transition planning of a problem-solving / decision-making nature	Palmer, 2012; Wehmeyer et al., 2000
Group sessions: managing health	Not included in CC's programme theory	Skills training and tips to better manage physical and mental health in a work environment	Mueser et al., 2005
Job coaching or facilitating entry into employment	Facilitating employment	Job coaching	Accordino & Herbert, 2000; Watzke et al., 2009
		Facilitated entry into employment	Hillier et al., 2007
Occupational therapy group sessions: interpersonal skills development and social events	Social component and participation and inclusion component	Social skills training	Mueser et al., 2005; Watzke et al., 2009; Tsang & Pearson, 2001
Recreational activities and vocational skills development	Vocational skills component	Computer skills, word processing and numeracy training	Watzke et al., 2009
		Unspecified pre-vocational skills training	Accordino & Herbert, 2000; Smit et al., 2014; Wehmeyer et al., 2000
		Vocational skills training	Hillier et al., 2007
		Craft workshops	Hall, 2013
Self-regulation activities	Vocational skills component (learning to share art supplies)	Learning to self-direct and regulate	Palmer et al., 2012; Wehmeyer et al., 2000
Sheltered employment	Not included in CC's programme theory	Facilitated sheltered employment	Accordino & Herbert, 2000; Watzke et al., 2009
Transferring skills to a new context	Juggling balls component and transference component	Applying skills learnt in the programme in new settings	Tsang & Pearson, 2001

Table K2

Outcomes Classification for the Vocation and Rehabilitation Programme

Broad outcome	CC's outcome	Description of outcome in publication	Reference to publication
Community participation / inclusion	Actively engaged in society (the extent of engagement is different for CC's beneficiaries and is dependent on their individual abilities and preferences)	Increased community participation and engagement with community	Hall, 2013
Employment	Some YAwD are commissioned to make crafts	Retaining a job	Hall, 2013; Hillier et al., 2007; Watzke et al., 2009
Goal attainment (individually set goals)	Some YAwD are commissioned to make crafts, others strengthen their ability to make crafts (this is dependent on personal goals)	Achieving individual goals related to transition from school to working life	Palmer et al., 2012; Wehmeyer et al., 2000
Knowledge gain (employment related)	Not included in CC's programme theory	Increased knowledge of the working environment	Mueser et al., 2005
Increased interpersonal skills	YAwD gain confidence required to interact with others	Exposure to group settings to practice social skills	Hall, 2013
		Improved personal competence	Smit et al., 2014
		Improved social skills in a work environment	Tsang & Pearson, 2001
Increased engagement in occupational domain other than work	YAwD experience an increase in meaningful engagements with peers	Engagement in recreation that is of personal value	Hall, 2013
		Increased feelings of pleasure and feelings of relatability to staff	Smit et al., 2014;

Table K2 Continued

Outcomes Classification for the Vocation and Rehabilitation Programme

Increased versatility	Increased versatility / dynamic behaviour in YAwD	Programme participants were able to generalize skills learnt on the programme to new context	Tsang & Pearson, 2001
Prevocational activity / skills development	YAwD's craft skills are strenghened	Improvement in artistic ability	Hall, 2013
Problem solving abilities increase	Not included in CC's programme theory	Increased ability to problem solve	Wehmeyer et al., 2000
Sense of independence in decision-making / self-determination and self-efficacy	YAwD gain confidence in making autonomous decisions, YAwD initiate making decisions and YAwD increase in self-efficacy	Increased self-efficacy	Hall, 2013
		Increased self-determination	Palmer, 2012, Smit et al., 2014; Wehmeyer et al., 2000

Appendix L: MCDA Comparison Matrices for the Classroom Component of the Inclusive Education Programme

Appendix L documents the sources of inconsistencies as well as all the comparison matrices from the Classroom component's MCDA. The evaluator had to adjust for inconsistent judgements provided by individual DMs. This was done to reduce CR values (a value indicating the degree to which judgements are inconsistent).

Table L1 displays the sources of inconsistencies and reports on how these were adjusted. The first column indicates the DM's reference, the second column reports on the original CR value for a given DM before adjusting for inconsistency. The third column indicates the source of inconsistency by stating which pairwise judgement contributed to a high CR value. The fourth column indicates the original judgement for the pairwise comparison whereas the second last column indicates the value of two (adjusted judgement value). Chapter three stated that Mu and Pereyra-Rojas (2017) recommend that inconsistent judgements be reduced to a value of two. Reducing a DM's judgement to a value of two does not change which criterion a DM chose as most important, rather it reduces the intensity of the preference. The degree to which one criterion is seen as more important in relation to another criterion is reduced (Mu & Pereyra-Rojas, 2017). This results in smaller Consistency Ratio values. Lastly, the preferred criterion is seen in the last column and is termed the dominant element. See Table L1.

Table L1

Adjusting Inconsistencies for the Classroom Component of the Inclusive Education Programme

DM	Original CR	(Sub) Criteria / (Sub) Criteria	Judgement	Adjusted	Dominant element
DM 1	0,2980	Cost / qualification	5	2	Qualification
		Skills development / upskilling teachers	8	2	Upskilling teachers
		Identification of disabilities / upskilling teachers	8	2	Upskilling teachers
		Designing programme activities / qualification	7	2	Designing programme activities
		Identification of disabilities / qualification	5	2	Identification of disabilities
DM 2	0,3917	Sense of identity / general wellbeing	5	2	General wellbeing
		Sense of identity / pre-schoolers communication	3	2	Sense of identity
		General wellbeing / pre-schooler's inclusivity	5	2	Pre-schooler's inclusivity
		General wellbeing / pre-schooler's communication	3	2	Pre-schooler's communication
DM 3	0,1321	Designing activities / upskilling teachers	7	2	Upskilling teachers
DM 4	1,1362	Creativity / general wellbeing	9	2	General wellbeing
		Sense of identity/ general wellbeing	8	2	Sense of Identity
		Sense of identity/ creativity	7	2	Sense of identity
		Pre-schoolers inclusivity / communication	9	2	Pre-schoolers inclusivity
DM 5	0,3515	Designing activities / identification of disabilities	9	2	Identification of disabilities
		Designing activities / qualification	7	2	Designing activities
		Identification of disabilities / upskilling teachers	5	2	Upskilling teachers
		Designing activities / skills development of pre-schoolers	5	2	Skills development of pre-schoolers

Table L2 below displays the comparison matrix showing how DMs weighted programme criteria for this programme component. The reader will notice there are grey and white cells. The grey cells can be disregarded as these are generated automatically by Super Decisions v2 and do not reflect DMs' judgements. These values are used to calculate Consistency Ratios. The DM's judgements for pairwise comparisons are recorded in the white cells. The first judgement shown in the comparison matrix (0,2814) is for cost (seen in the column on the left) versus designing activities (seen in the first row). The second judgement is 0,2313 for cost (seen in the column on the left) versus identification of disabilities (second white cell in the first row).

Table L2

Pairwise Judgements and Weighted Criteria for the Classroom Component of the Inclusive Education Programme

	Criteria					
	Cost	Designing activities	Identification of disabilities	Qualification	Skills development	Upskilling teachers
Criteria						
Cost	1,0000	0,2814	0,2313	0,2508	0,1748	0,1554
Designing activities	3,5537	1,0000	1,2457	2,2679	0,6988	0,8706
Identification of disabilities	4,3234	0,8028	1,0000	1,0000	0,3081	0,3981
Qualification	3,9872	0,4409	1,0000	1,0000	0,3081	0,3624
Skills development	5,7208	1,4310	3,2457	3,2457	1,0000	0,5899
Upskilling teachers	6,4350	1,1486	2,5119	2,7594	1,6952	1,0000

Note. CR = 0,0277.

Table L3 displays the DMs' pairwise judgements for sub-criteria of skills development. This table is similar to L2, however, sub-criteria, as opposed to criteria, are reported on. The reader is reminded that all pairwise judgements are shown in the white cells, the grey cells are used to calculate Consistency Ratio values.

Table L3

Pairwise Judgements for Sub-Criteria of the Skills Development Criterion for the Classroom Component of the Inclusive Education Programme

		Sub-Criteria			
Criteria	Sense of identity and belonging	Creativity	Wellbeing	Pre-schoolers' inclusivity	Communication
Sense of identity and belonging	1,0000	2,0477	0,7579	0,5610	0,8198
Creativity	0,4884	1,0000	0,5942	0,3010	0,4152
Wellbeing	1,3194	1,6829	1,0000	0,5610	0,7740
Pre-schoolers' inclusivity	1,7825	3,3223	1,7825	1,0000	1,0371
Communication	1,2198	2,4085	1,2920	0,9642	1,0000

Note. CR = 0,0065.

Table L4 records the pairwise judgements for preferences of alternatives for the classroom component of the Inclusive Education Programme. In Table L4, the criteria and sub-criteria are listed in the first column on the left. For each (sub) criterion, DMs indicated whether they prefer community workers or occupational therapists. The white cells contain values which reflect these preferences. The first judgement (3,6801) is for community workers versus occupational therapists in relation to the identity and belonging sub-criterion. The grey cells are used for Consistency Ratio calculation purposes and can be disregarded.

Table L4

Pairwise Judgements for Alternatives for the Classroom Component of the Inclusive Education Programme

Criteria / Sub-criteria	Alternatives	Judgement	Judgement
Identity and belonging		Community worker	Occupational therapist
	Community worker	1,0000	3,6801
	Occupational therapist	0,2717	1,0000
Creativity		Community worker	Occupational therapist
	Community worker	1,0000	0,8706
	Occupational therapist	1,1486	1,0000
General wellbeing		Community worker	Occupational therapist
	Community worker	1,0000	0,6776
	Occupational therapist	1,4758	1,0000
Pre-schoolers being more inclusive of people with disabilities		Community worker	Occupational therapist
	Community worker	1,0000	0,7248
	Occupational therapist	1,3797	1,0000
Communication		Community worker	Occupational therapist
	Community worker	1,0000	1,2011
	Occupational therapist	0,8326	1,0000
Cost		Community worker	Occupational therapist
	Community worker	1,0000	0,6118
	Occupational therapist	1,6345	1,0000
Designing activities		Community worker	Occupational therapist
	Community worker	1,0000	0,2144
	Occupational therapist	4,6642	1,0000
		Community worker	Occupational therapist
Identification of disabilities	Community worker	1,0000	0,2947
	Occupational therapist	3,3933	1,0000
Qualification		Community worker	Occupational therapist
	Community worker	1,0000	0,8706
	Occupational therapist	1,1486	1,0000
Upskilling teachers		Community worker	Occupational therapist
	Community worker	1,0000	0,3749
	Occupational therapist	2,6674	1,0000

Note. CR = 0,0000.

Appendix M: MCDA Comparison Matrices for the Parent Component of the Inclusive Education Programme

Appendix M documents the sources of inconsistencies as well as all the comparison matrices from the parent component's MCDA.

The evaluator had to adjust for inconsistent judgements provided by individual DMs. This was done to reduce CR values (a value indicating the degree to which judgements are inconsistent). As a recap, inconsistent judgements refer to contradictory judgements.

Table M1 displays the sources of inconsistencies and reports on how these were adjusted. The first column indicates the DM's reference, the second column reports on the original CR value for a given DM before adjusting for inconsistency. The third column indicates the source of inconsistency by stating which pairwise judgement contributed to a high CR value. The fourth column indicates the original judgement for the pairwise comparison whereas the second last column indicates the value of two (adjusted judgement value). Chapter three stated that Mu and Pereyra-Rojas (2017) recommend reducing judgements to a value of two. This results in smaller CR values. Lastly, the preferred criterion is seen in the last column and is termed the dominant element. See Table M1.

Table M1

Sources of Inconsistencies and Adjustments for the Parent Component of the Inclusive Education Programme

DM	Original CR	Criteria / criteria	Judgement	Adjusted	Dominant element
DM 1	0,79734	Supporting readiness / emotional support	9	2	Supporting readiness
		Qualification / emotional support	8	2	Emotional support
		Qualification / supporting readiness	7	2	Qualification
		Designing activities / developmental education	8	2	Designing activities
		Supporting readiness / cost	9	2	Supporting readiness
		Cost / emotional support	8	2	Emotional support
		Qualification / cost	8	2	Qualification
DM 2	0,44716	Supporting readiness / emotional support	9	2	Supporting readiness
		Designing / developmental education	9	2	Developmental education
		Qualification / cost	5	2	Qualification
		Developmental education / emotional support	9	2	Emotional support
		Supporting readiness / educational development	9	2	Supporting readiness
		Designing activities / emotional support	9	2	Emotional support
DM 3	0,22697	Qualification / cost	5	2	Qualification
		Qualification / designing activities	4	2	Designing activities
DM 4	0,50798	Qualification/ supporting readiness	5	2	Qualification
		Supporting readiness / emotional support	4	2	Supporting readiness
		Supporting readiness / cost	7	2	Supporting readiness
		Qualification / emotional support	5	2	Emotional support
		Qualification / cost	3	2	Cost
		Supporting readiness / developmental education	5	2	Developmental education
		Developmental education / emotional support	4	2	Developmental education
		Cost / developmental education	5	2	Developmental education
		Cost / emotional support	3	2	Emotional support
DM 5	0,10858	Designing activities / developmental education	5	2	Developmental education

Table M2, below, displays the comparison matrix showing how DMs weighted programme criteria for this programme component. The reader will notice there are grey and white cells. The grey cells can be disregarded as these are generated automatically by Super Decisions v2 and do not reflect DMs' judgements. These values are used to calculate Consistency Ratios. The DM's judgements for pairwise criteria are recorded in the white cells. The first judgement shown in the comparison matrix (0,4055) is for qualification (seen in the column on the left) versus supporting readiness (seen in the first row). The second judgement is 1,5131 for qualification (seen in the column on the left) versus cost (second white cell in the first row).

Table M2

Pairwise Judgements for the Criteria for the Parent Component of the Inclusive Education Programme

		Criteria				
Criteria	Qualification	Supporting readiness	Cost	Designing activities	Developmental education	Emotional support
Qualification	1,0000	0,4055	1,5131	0,1960	0,2073	0,2327
Supporting readiness	2,4661	1,0000	3,0182	1,1029	0,9347	1,1776
Cost	0,6609	0,3313	1,0000	0,3376	0,1951	0,2507
Designing activities	5,1020	0,9067	2,9621	1,0000	0,8909	1,0108
Developmental education	4,8239	1,0699	5,1256	1,1225	1,0000	1,1776
Emotional support	4,2974	0,8492	3,9888	0,9893	0,8492	1,0000

Note. CR = 0,0165.

Table M3 records the pairwise judgements for preferences of alternatives for the Parent component of the Inclusive Education Programme. In Table M3, the criteria are listed in the first column on the left. For each criterion, DMs indicated whether they prefer community workers or occupational therapists. The white cells contain values which reflect these preferences. The first judgement (0,4055) is for community workers versus occupational therapists in relation to the qualification criterion. The grey cells are used for Consistency Ratio calculation purposes and can be disregarded.

Table M3

Pairwise Judgements for Alternatives for the Parent Component of the Inclusive Education Programme

Criteria	Alternatives	Judgements	
		Community Worker	Occupational Therapist
Qualification	Community Worker	1,0000	0,4055
	Occupational Therapist	2,4661	1,0000
		Community Worker	Occupational Therapist
Supporting readiness	Community Worker	1,0000	0,9590
	Occupational Therapist	1,0428	1,0000
		Community Worker	Occupational Therapist
Cost	Community Worker	1,0000	1,1029
	Occupational Therapist	0,9067	1,0000
		Community Worker	Occupational Therapist
Designing activities	Community Worker	1,0000	0,1554
	Occupational Therapist	6,4350	1,0000
		Community Worker	Occupational Therapist
Developmental education	Community Worker	1,0000	1,8171
	Occupational Therapist	0,5503	1,0000
		Community Worker	Occupational Therapist
Emotional support	Community Worker	1,0000	3,7316
	Occupational Therapist	0,2680	1,0000

Note. CR = 0,0000.

Appendix N: MCDA Comparison Matrices for the Vocation and Rehabilitation Programme

Appendix N documents the sources of inconsistencies as well as all the comparison matrices from the Vocation and Rehabilitation Programme's MCDA.

The evaluator had to adjust for inconsistent judgements provided by individual DMs. This was done to reduce CR values (a value indicating the degree to which judgements are inconsistent).

Table N1 displays the sources of inconsistencies and reports on how these were adjusted. The first column indicates the DM's reference, the second column reports on the original CR value for a given DM before adjusting for inconsistency. The third column indicates the source of inconsistency by stating which pairwise judgement contributed to a high CR value. The fourth column indicates the original judgement for the pairwise comparison whereas the second last column indicates the value of two (adjusted judgement value). This results in smaller Consistency Ratio values. Lastly, the preferred criterion is seen in the last column and is termed the dominant element. See Table N1.

Table N1

Sources of Inconsistencies and Adjustments for the Vocation and Rehabilitation Programme

DM	Original CR	Criteria / Criteria	Judgement	Adjusted	Dominant element
DM 1	0,1661	Creating an accepting environment / facilitate entry into the workforce	5	2	Facilitate entry into the workforce
		Cost / skill to identify YAwD to enter the workforce	4	2	Skill to identify YAwD to enter the workforce
		Creating an accepting environment / skill to identify YAwD to enter the workforce	4	2	Skill to identify YAwD to enter the workforce
		Cost / qualification	5	2	Qualification
		Facilitate social integration / teaching useful skills	5	2	Teaching useful skills
DM 2	0,1854	Creating an accepting environment / design activities	9	2	Creating an accepting environment
		Design activities/ teaching useful skills	3	2	Design activities
		Cost / qualification	9	2	Qualification
		Cost / transfer skills and knowledge	9	2	Transfer skills and knowledge
		Cost / skill to identify YAwD to enter the workforce	9	2	Skill to identify YAwD to enter the workforce
DM 3	0,3380	Cost / qualification	9	2	Qualification
		Facilitate entry into the workforce / skills to identify YAwD to enter the workforce	9	2	Facilitate entry into the workforce
		Facilitate social integration / teaching useful skills	9	2	Teaching useful skills
		Design activities / qualification	8	2	Design activities
		Creating a safe environment / teaching useful skills	7	2	Teaching useful skills
		Design activities / facilitate social integration	9	2	Facilitate social integration
		Skill to identify YAwD to enter the workforce / teaching useful skills	8	2	Skill to identify YAwD to enter the workforce
		Facilitate entry into the workforce / teaching useful skills	9	2	Facilitate entry into the workforce
		Qualification / transfer skills and knowledge	9	2	Transfer skills and knowledge
		Facilitate social integration / qualification	9	2	Facilitate social integration
		Create a safe environment / qualification	8	2	Creating an accepting environment

Table N1 Continued

Sources of Inconsistencies and Adjustments for the Vocation and Rehabilitation Programme

DM 4	0,3430	Creating an accepting environment / facilitate entry into the workforce	7	2	Creating an accepting environment
		Creating an accepting environment / facilitate social integration	8	2	Facilitate social integration
		Creating an accepting environment / transfer skills and knowledge	6	2	Transfer skills and knowledge
		Creating an accepting environment / identify YAwD to enter the workforce	7	2	Identify YAwD to enter the workforce
		Facilitate social integration / qualification	5	2	Facilitate social integration
		Qualification / transfer skills and knowledge	5	2	Transfer skills and knowledge
		Creating an accepting environment / qualification	4	2	Creating an accepting environment
		Facilitate entry into the workforce / facilitate social integration	4	2	Facilitate entry into the workforce
		Creating an accepting environment / teaching useful skills	7	2	Teaching useful skills
DM 5	0,1060	Transfer skills and knowledge / teaching useful skills	5	2	Transfer skills and knowledge

Table N2 below displays the comparison matrix showing how DMs weighted programme criteria for this programme. The reader will notice there are grey and white cells. The grey cells can be disregarded as these are generated automatically by Super Decisions v2 and do not reflect DMs' judgements. These values are used to calculate Consistency Ratios. The DM's judgements for pairwise criteria are recorded in the white cells. The first judgement shown in the comparison matrix (0,2039) is for cost (seen in the column on the left) versus creating an accepting environment (seen in the first row). The second judgement is 0,3801 for cost (seen in the column on the left) versus designing programme activities (second white cell in the first row).

Table N2

Pairwise Judgements for Criteria for the Vocation and Rehabilitation Programme

	Criteria								
Criteria	Cost	Creating an accepting environment	Design activities	Facilitate entry into workforce	Facilitate social integration	Qualification	Skill to identify YAwD to enter workforce	Transfer knowledge and skills	Teach useful skills
Cost	1,0000	0,2039	0,3801	0,1688	0,1688	0,3589	0,2398	0,1997	0,1382
Creating an accepting environment	4,9044	1,0000	1,5849	1,4509	0,6310	2,5508	0,7579	0,9791	0,5493
Designing activities	2,6309	0,6310	1,0000	0,8891	0,5610	1,7826	1,0000	1,2457	0,6084
Facilitate entry into workforce	5,9242	0,6892	1,1247	1,0000	0,6345	0,9441	1,4310	1,2920	0,4307
Facilitate social integration	5,9242	1,5848	1,7825	1,5760	1,0000	3,3659	1,3797	1,9332	0,6397
Qualification	2,7863	0,3920	0,5610	1,0592	0,2971	1,0000	0,8027	0,5493	0,2181
Skill to identify YAwD to enter workforce	4,1701	1,3194	1,0000	0,6988	0,7248	1,2458	1,0000	1,2457	0,4066
Transfer knowledge and skills	5,0075	1,0213	0,8028	0,7740	0,5173	1,8205	0,8028	1,0000	0,4471
Teach useful skills	7,2359	1,8205	1,6437	2,3218	1,5632	4,5851	2,4594	2,2366	1,0000

Note. CR = 0,0181.

Table N3 records the pairwise judgements for preferences of alternatives for the Parent component of the Inclusive Education Programme. In Table N3, the criteria are listed in the first column on the left. For each criterion DMs indicated whether they prefer community workers or occupational therapists. The white cells contain values which reflect these preferences. The first judgement (0,4055) is for community workers versus occupational therapists in relation to the qualification criterion. The grey cells are used for Consistency Ratio calculation purposes and can be disregarded. See Table N3.

Table N3

Pairwise Judgements for Alternatives for the Vocation and Rehabilitation Programme

Criteria	Alternatives	Pairwise Judgements	
		Community worker	Occupational therapist
Cost	Community worker	1,0000	0,2559
	Occupational therapist	3,9078	1,0000
		Community worker	Occupational therapist
Creating an accepting environment	Community worker	1,0000	0,5533
	Occupational therapist	1,8073	1,0000
		Community worker	Occupational therapist
Designing activities	Community worker	1,0000	0,1406
	Occupational therapist	7,1124	1,0000
		Community worker	Occupational therapist
Facilitate entry into the workforce	Community worker	1,0000	0,1524
	Occupational therapist	6,5617	1,0000
		Community worker	Occupational therapist
	Community worker	1,0000	0,7079
Facilitating social integration	Occupational therapist	1,4126	1,0000
		Community worker	Occupational therapist
Qualification	Community worker	1,0000	0,5533
	Occupational therapist	1,8073	1,0000
		Community worker	Occupational therapist
Identifying YAwD to enter the workforce	Community worker	1,0000	0,3621
	Occupational therapist	2,7617	1,0000
		Community worker	Occupational therapist
Transferring skills and knowledge	Community worker	1,0000	0,2565
	Occupational therapist	3,8986	1,0000
		Community worker	Occupational therapist
Teaching useful skills	Community worker	1,0000	0,2398
	Occupational therapist	4,1701	1,0000

Note. CR = 0,0000.